Cambodia Postabortion Care Program

Final Report of Findings and Recommendations

Cambodia Trip Report:
Dates April 25, 2005 to May 6, 2005

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List of Abbreviations

ANC	Antenatal Care
BCC	Behavior Change Communication
BS	Birth spacing
COPE®	Client Oriented Provider Efficient
CTO	Cognizant Technical Officer
D&C	Dilatation and curettage
DHS	Demographic Health Surveys
DOTS	Direct Observation of Treatment
EH	EngenderHealth
FP	Family planning
GH	Global Health
HIV	Human immunodeficiency virus
IEC	Information, Education, Communication
LSS	Life Saving Skills
MPA	Minimum program activities
MVA	Manual vacuum aspiration
NGO	Non-governmental organization
PAC	Postabortion Care
OD	Operational Districts
RACHA	Reproductive and Child Health Association
RC	Red Cross
RHCA	Reproductive Health Association of Cambodia
SIS	Self Improvement Systems (Quality Improvement initiative)
STI	Sexually transmitted infections
VCCT	Voluntary confidential counseling and testing for HIV
VSC	Voluntary surgical contraception
USAID	United States Agency for International Development

Executive Summary

Until recently, USAID/Cambodia's role in support of PAC has been limited. The Office of Public Health is now in a position to implement a PAC strategy in collaboration with government and NGO partners. In an effort to provide technical support to its new PAC program, USAID/Cambodia requested a visit from the PAC Team Leader in USAID/Washington. The purposes of the visit were to 1.) assist USAID/Cambodia with its strategy for postabortion care (PAC); 2.) assist OPH/USAID Cambodia to review and assess current PAC activities and make recommendations for new activities under the new Mission Strategy (2006-2010); 3.) ensure consistency with the USAID PAC Strategy and Mexico City Policy; and 4.) evaluate the usefulness of the draft USAID Global PAC Resource Package in Cambodia for the scale-up of PAC activities.

The methodology for the evaluation visit consisted of interviews with staff from USAID/Cambodia; CARE; RHAC; RACHA; the Ministry of Health; and Directors of operational districts. Site visits were made to health centers, community education sessions; and the Red Cross Hospital. Numerous documents were reviewed which included national policy documents; PAC curriculum currently in use for training; service delivery guidelines; USAID/Cambodia postabortion care draft strategy;

Overall findings of the assessment of PAC activities in Cambodia found that the PAC activities appear to be in compliance with Mexico City Policy and the Helms Amendment. Further assessment of adherence to Mexico City Policy will be completed by USAID/Washington during site visit scheduled for June, 2005.

There were a number of challenges noted in postabortion training and the delivery of postabortion care services. While postabortion care training has occurred for 100 midwives since 2003 the providers are not confident in their skills; the training has not been complete. Postabortion care training does not provide clinical practice experience for building competence and confidence in managing uterine evacuation techniques and for developing clinical judgment. While the curriculum schedule provides for a time of pre and post testing; there are no tools to indicate that the learner has demonstrated proficiency in theoretical or clinical knowledge attainment. . Directors and staff of all sites visited value PAC training for service delivery and request that more providers be trained. However, they request that clinical experience be part of the training and request post training follow-up/supervision to reassure that they are "doing the right thing". In the June 2004 baseline study done by RACHA, women in the community had a greater knowledge of danger signs and risks/complications related to unsafe abortion and miscarriage than the midwives practicing in the community. Therefore it is critical to establish a standard of 85% competency in theoretical and clinical skills knowledge.

Challenges with the delivery of postabortion care services are that reorganization of services have not occurred in all facilities. This would allow women to receive a family planning method at the same time and location as PAC emergency treatment. When patients are referred to family planning services within the facility, there is no tracking to ascertain whether the client kept her appointment and received counseling and/or a method. The sites wherein postabortion services are being provided have the potential for the integration of STI and HIV services that are currently present in these facilities.

The community is seen as a vital component in strengthening the quality of services in health facilities. Since 2004 there has been a community awareness program to educate the community re: danger signs and risks related to unsafe abortion and miscarriage. This program has been very successful. More than 3000 community residents, TBAs and Volunteer Health Support Groups have been educated. But the number of patients referred to health facilities due to complications of unsafe abortion/miscarriage by VHSGs and TBAs was extremely few with the total number of 4 referrals noted in statistics that were made available.

While the community mobilization program has been successful in providing information to the communities, these activities do not seem to have any direct bearing on the increase in PAC services in the health facilities servicing these communities. Increases in PAC caseloads were seen at health facilities where the surrounding communities did not have PAC community mobilization activities.

Since the initiation of the postabortion care program in 2004, PAC services are now occurring at 11 sites in Cambodia in three operational districts (OD). Projections for PAC caseloads for each site based upon the number of client visits during the first quarter of 2005 indicate that each OD has one site wherein there is a clear demand for PAC services

[1] Ibid, "Background".

and the caseload is high enough to justify strengthening the site to accept a greater patient caseload and prepare it as a site for clinical training. The projections also indicate that all three ODs have sites in which there has been either a decrease or little to no increase in services. This information helps to determine patient demand for PAC services as well as indicate those areas in which further community mobilization is needed to create demand.

Review of the draft USAID/Cambodia PAC strategy found that the document was very inclusive. Additional information needed includes the new USAID PAC model, the results framework, and global and country indicators. The draft User's Guide of the USAID Global PAC Resource Package was found to be useful for USAID/Cambodia and partners to take a comprehensive look at PAC program considerations by enabling a systematic approach to assessing what would be needed to start PAC services and/or scaling-up existing services.
Four documents in the IEC/BCC section of the draft Global PAC Resource Package had been already adapted for use in Cambodia.

Some Recommendations to USAID/Cambodia as a result of this assessment include the following;
1. USAID/Cambodia consider postponing future PAC training for additional providers until current PAC activities can be strengthened. This would be achieved by a). establishing a standardized curriculum and examination to evaluate theoretical knowledge and clinical competency; b). establish standardized service delivery guidelines; c). establish a method to evaluate the theoretical and clinical skills proficiency of all providers previously trained. A minimum passing score of 85% on the written examination and demonstration of clinical skills on a model utilizing a skills checklist is recommended; d. establish a supervision system for PAC to ensure transfer of learning to the clinical environment. Due to the current lack of patient numbers, it is recommended that clinical training opportunities be sought outside of Cambodia to ensure that competency in clinical and counseling skills can be attained.

2. Ensure that a needs assessment re: incidence of hospital admissions or health facility encounters due to complications related to unsafe abortion or miscarriage; CPR, and TFR is completed for each village/community in which PAC services are desired. This will be important to justify the placement of PAC services when planning future scale-up of services. Consider establishing tiered PAC services wherein one or two health facilities are designated to provide PAC uterine evacuation; and other health facilities in the area will provide evaluation/triage/stabilization of the patient with ability to transfer to the designated health facility for uterine evacuation.

3. Assist health facilities to reorganize family planning services so that family planning counseling and methods are available at the same time and in the same location of PAC emergency treatment. Also include men in the Family planning counseling sessions. Research indicates that both of these measures increase the acceptance of a family planning method.

4. The community awareness project that is currently ongoing presents a top down approach to educating the community wherein the providers determine the topics for discussion. Review of the PAC Community mobilization program done in Bolivia may be useful in mobilizing the many community groups to discuss the issues related to complications of miscarriage and unsafe abortion.

5. Ensure that postabortion care services are clearly covered as an obstetrical emergency service which is covered under the Equity Fund. This will remove barriers for women seeking PAC services.

Background

Cambodia's Demographic Snapshot

Population – 13.1 million; women account for 51.8% of total population
Annual growth estimated at 2.5%
Total fertility rate (TFR) – 4.0 per woman
Contraceptive prevalence rate (CPR) is 19%
Life expectancy at birth - 58.3% (females) and 54.5% for (males)*

Source: Kingdom of Cambodia, MOH, Health Sector Strategic Plan 2004-2007; 2001 data; *1998 data

Cambodia ratified a liberal abortion law in 1997 with the operational guidance (Prakas) for that law to go into effect issued 2002.[2] The Prakas functions to facilitate implementation of standardized, safe, and legal abortion services during the first 12 weeks of pregnancy. Despite the liberalization of abortion, its legal status is not widely known and services are of sufficiently variable quality resulting in complications of abortion ranking as the second cause of maternal mortality, following postpartum hemorrhage.[3] Repeat abortions are common for a variety of social, economic, and access factors even though contraceptive prevalence has increased, as has the availability of family planning.

The current maternal mortality ratio in Cambodia is estimated to be 437/100,000 live births, due to complications of childbearing. The Cambodia DHS conducted in 2000 estimated a 5% prevalence of abortion among women but common perceptions among health professionals are that this percentage reflects significant under reporting.[4] Underreporting of abortion-related events are related to the sensitivity surrounding abortion for women, stigma; difficulties in documenting data, and collecting reliable date by providers of services.

While the Ministry of Health (MOH) has made maternal and child health a high priority with the strategic plan for safe motherhood including abortion care, the MOH does not promote abortion as a method of family planning. The environmental factors that facilitate abortion complications demonstrate an urgent need for postabortion care (PAC). Until recently, PAC support has been minimal and limited to assistance from EngenderHealth through funding from the Packard Foundation and an anonymous donor. In 2003, EngenderHealth, in collaboration with a USAID/Cambodia project called the Reproductive and Child Health Alliance (RACHA) provided the first formal PAC training for a group of MOH midwives. Under this grant, EngenderHealth provided technical assistance to RACHA to further build capacity among providers and expand the reach of PAC services throughout Cambodia.[5] Also during the grant period, EngenderHealth supported RACHA in conducting PAC orientation meetings, a PAC evaluation workshop to forge linkages with in-country institutions, participated in key meetings with USAID, MOH, and other stakeholders to increase awareness and build support for PAC Cambodia.[6] Through the grant implementation process, RACHA transitioned from an organization that received two PAC trainings in 2004 to a significant NGO in the country implementing a comprehensive PAC program.

USAID/Cambodia's role in support of PAC has been limited until now. The Office of Public Health is now in position to implement a PAC strategy in collaboration with government and NGO partners. Global Leadership Priority funding from the USAID/Washington PAC Working Group provides, USAID/Cambodia with an opportunity to support strategic interventions, such as:

1) Improved policy environment for PAC,
2) Increased availability and access to quality PAC services, and
3) Improved community practices and support for PAC.

[2] Cambodia Abortion Law, 1997; Declaration on the Guidelines for the Execution of the Abortion Law, 2002.
[3] Ahlborg, Jean, M.D., Trip Report / Cambodia / November 5, 2004; "Background".
[4] Ibid, "Background".
[5] *Building Capacity and Sustainability: Taking Postabortion Care Services to Scale*, Final Report, 2004; page 7.
[6] Ibid, page 8.

U**SAID/Cambodia**
Persons Contacted: Dr. Charya Hen; Dr. Chantha Chak

The MOH plan is to improve access to services. In Cambodia there are 75 Operational Districts each providing medical coverage to 100,000 to 200,000 people; 935 health centers; 65% of these centers provide the minimal package of activities which include Family Planning and immunization. Ninety percent of births are done at home.

The PHN strategy of 2002-2005 included four guiding principles. It collaborates with national policies and strategies, integrates HIV/AIDS; concentrates on priority persons; and builds capacity.

The third principle of the strategy is reproductive health. Its goal is to prevent the transmission of HIV from husband to wife and mother to infant and seeks to expand care and support to HIV/AIDS.

In TB programs, USAID works with partner organizations to expand DOTS. In MCH, USAID's work is facility, home, and community based. Transportation is an issue. !2% of the births are done by midwives. TBAs do 60% of the home births. USAID has been working with TBAs in the areas of clean delivery and infection prevention by providing home birth kits. RACHA is working on establishing partnerships between the TBAs and midwives to increase the use of the partograph and to arrange a referral system. The TBA/Midwife alliance provides a card book/register book in which one can record the number of pregnant women; the number of women who have delivered; and the number of women referred for complications. The TBAs have a training curriculum which teaches them about when they should assess the patient and makes the TBAs aware of high risk criteria that would prompt the need for referral. Guidelines are needed for the midwife/TBA alliance. There is active management of emergency obstetrical care. Assistance is needed to revise the national guidelines for Vitamin A.

Reproductive health services include a) facility based and community based family planning;
b) adolescent reproductive health; and c) HIV/AIDS prevention. PAC services include postabortion family planning counseling and services; referral to other reproductive health services; early cervical cancer screening.

The desire of USAID is to build capacity of the government staff in postabortion care; to assist in the development of a national PAC policy and training curriculum; ensure PAC service delivery, to do community awareness activities that will discuss postabortion warning signs. family planning methods, availability of PAC services, and referral for PAC services. USAID/Cambodia also desires to do health systems strengthening by making PAC services accessible by increasing the quality of PAC services, address human resources, equipment, and financial barriers by supporting the Equity Fund of the MOH; and building capacity. None of the NGOs are providing assistance on referral; therefore this area may not be very strong. The role of the community in PAC is to decide what cases should be referred and where the referral should be made. There is community drama occurring to increase community awareness. RACHA has a micro credit program which provides assistance with referral for emergencies.

The cross cutting themes and approaches are to change policy to support outreach.

National Maternal and Child Health Center
Person Contacted: Dr. Koum Kanal

Cambodia has problems with maternal mortality. Currently the CPR in Cambodia is 24%. Sixty six percent (66%) of pregnant women in Cambodia are anemic. The women believe that if there is bleeding during the pregnancy then it is an indication of neonatal abnormalities.
The MOH does not consider abortion as a family planning method in Cambodia, but there is concern regarding how to make abortion safer in an effort to decrease maternal mortality. The strategy in Cambodia is how to solve the problem of complications related to unsafe abortion. There is a need to have quality services for postabortion care. Patients only present for real complications. They do not come back if they have to wait and the services are poor quality.

There is the need to fix the duration of PAC training. Complicated cases come to the health center, however there are not enough patients for clinical practice in order to improve the quality of care, one needs to have clients. The National Maternal and Child Health Center has been using MVA for more than 5 years. If the pregnancy is greater than 14 weeks, then D&E or misoprostil is used. Dilatation of the cervix is not necessary as the cervix is already open in spontaneous abortion. In about 30% of cases, curettage is used for retained placenta.

There is concern about how one can separate abortion and postabortion care services in the health center. 19% of the people live in rural areas; Cambodia has 963 health centers. In many of these centers there is only one midwife. Curettage is provided in the health centers. Training is needed in D&C even though D&C has been present in the health centers. There is the need for preservice curriculum for PAC and counseling. The question is how can one coordinate postabortion care services and abortion services in the health center with few staff and limited room for services? Safe abortion services are only included in the comprehensive package of activities (CPA); it is not included in the minimal package of activities (MPA).

Dr. Kanal recognizes the concerns of Mexico City Policy. He is supportive of USAID doing whatever it can do without violating the Mexico City Policy. Some areas of assistance for USAID were identified such as support counseling; training in D&C; only providing post treatment family planning services if needed; community awareness and mobilization activities regarding unsafe abortion and family planning; maternal mortality related to unsafe abortion; family planning messages; MVA kits for postabortion care services. Cambodia government is not trying to promote abortion but rather reduce the incidence of unsafe abortion and maternal mortality.

It is uncertain as to whether IPAS will be providing safe abortion services as the funding for these services have not come through. MVA kits are available for comprehensive abortion care.

Assessment:
1. There is the need for training in family planning counseling, training regarding the management of complications related to unsafe abortion; and a pre-service curriculum for PAC.
2. Community awareness and mobilization activities are needed to provide information regarding risks of unsafe abortion and to create demand for postabortion care services.
3. Dr. Kanal is aware of the restrictions that USAID may have in providing support for services, however it is up to USAID how they would like to support Cambodia in the delivery of postabortion care services
4. Safe abortion care services are only a part of the comprehensive package of activities; it is not a part of the minimal package of activities.
5. Women in Cambodia are unaware of the many causes for bleeding in pregnancy and that there may not be any direct correlation to neonatal abnormalities

Recommendations:
1. USAID should provide support to Cambodia by assisting in the creation of in-service and pre-service PAC curriculum. Strengthen counseling for family planning and client-provider interaction by having adequate time for role/play; testing of theoretical knowledge in the curriculum
2. USAID can assist the MOH in determining which health centers should provide the comprehensive package of activities and which should provide the minimal package of activities. Establishment of good referral systems that include emergency transport would assist in making postabortion care services available to the community. Health centers providing the minimal package of activities could provide PAC services. Only those health facilities providing comprehensive package of activities would provide abortion services. This will probably be secondary or tertiary facilities wherein separate services for postabortion care could be established in a separate space from safe abortion care services. If necessary, there may be some areas in which post emergency treatment family planning services may only be able to be provided. While this seems like a small intervention, research from varied countries indicates its effectiveness in increasing family planning usage and decreasing repeat abortion.
3. USAID can assist the MOH in its community empowerment, awareness and mobilization activities by providing messages to the community that include family planning, danger signs/risks related to unsafe abortion; causes for bleeding in pregnancy. It is suggested that the PAC community mobilization activity done in Bolivia be reviewed for adaptation in Cambodia.

MOH, National Maternal Child Health
Person contacted: Dr. Rathavy, Deputy Director Reproductive Health/MCH Division

Dr. Rathavy provided an update on the plans within MOH/MCH division. Comprehensive abortion care and PAC are on parallel but separate tracks within the MOH system. On May 18, 2005, MOH is organizing a PAC Technical working Group with the task of producing guidelines for PAC services, review of training curricula, promotion of PAC, and monitoring of FP counseling. By the end of June '05, Dr. Rathavy would like to have a RH plan and strategy with PAC placed under unsafe abortion. The plan should also include moving PAC to the health center level. The work of this working group will respond to the need for standardization of guidelines, coordination of service components, e.g., hospital departments, drugs, records, etc.). When asked her feelings about incorporating PAC under the Safe Motherhood policy, Dr. Rathavy felt that is would be difficult to do this and that PAC would fit better under their strategy to reduce unsafe abortion, as this is a priority activity.

A concern articulated by Dr. Rathavy is that women use medicinal means to provoke bleeding in the presence of unwanted pregnancy then seek PAC for completion of induced abortion. Dr. Rathavy voiced frustration with PAC being used in this way and desires to find ways to stimulate change in women's practices.

A second concern aired by Dr. Rathavy was the interpretation of the Mexico City Policy and what that would mean for MOH services as they try to scale up PAC. Dr. Rathavy is also eager to receive support to continue expanding PAC services. The PAC Team Leader suggested that these questions be asked of Barbara Seligman (USAID/Washington) during her upcoming visit to Cambodia in June.

The PAC team shared with Dr. Rathavy information about the Global PAC Resource Package and its available sections were offered as a resource for the upcoming working group's tasks. Dr. Rathavy accepted and asked for it to made available as soon as possible.

Assessment:
1. Dr. Rathavy is interested in establishing national policy, curriculum and service delivery guidelines for postabortion care.
2. There is great interest in using the Global PAC Resource Package for completing the above named items. Dr. Rathavy requested that she be provided with the materials for use.
3. Dr. Rathavy Is interested in meeting with Barbara Seligman in discussing the Helms Amendment and Mexico City Policy for the scale up of PAC programs in Cambodia

Activities/Findings and Recommendations

CARE Cambodia

Persons Contacted: Sharon Wilkinson/CARE, Brian Lund/CARE,
Charya Hen, USAID/Cambodia

Background

Care's activities can be broken down into three linked focus areas: health systems support; community health system development and support; and behavior change interventions focused on youth based in their workplace. The estimated number of people directly accessing services through CARE per vulnerable group is as follows: 14,000 children under age one; 65,000 children under age five; 15,000 pregnant women; 71,000 married women of reproductive age; 4,512 people living with HIV/AIDS; 15,484 orphans and vulnerable children; 5,000 casino workers; 50,000 high school students, couples and other individuals vulnerable to HIV/AIDS and 50,000 garment workers.[7] An overview of these activities is noted below.

Health Systems support

CARE assists in national level health systems strengthening by working in policy development at the national level. Since 1995, CARE has partnered with the PHD and OD health teams, provides training and implementation of OD supervision in all technical areas, and increases the capacity of the senior OD/PHD management to develop, plan, and implement services that link to community systems and structures. CARE has integrated activities between the HIV and maternal child health departments in an effort to reduce the transmission of HIV between mother and child. They have worked to strengthen ANC services by including HIV prevention messages and use of life saving drugs like Nevirapine.

CARE has participated in health center capacity building by facilitating the training for hospital and clinic staff on HIV testing and post test counseling for pregnant women, the minimum package of services; facilitative supervision and follow-up; Life Saving Skills, birth spacing, ANC/PNC, EPI outreach, IMCI, STI management, interpersonal counseling (including VCCT where appropriate); and DOTS therapy for TB. CARE supports and ensures the quality of he MOH expanded package of outreach services (EPI, ANC, PNC, Vitamin A). They also support general system strengthening activities such as drug logistics, HIS and disease surveillance training, and training and inclusion of quality improvement methods such as COPE.[8]

Community Health System Support

Community health system support is evidenced by their work in Community Resilience and support of community health systems that promote healthy and protective behaviors. Community Resilience seeks to support individual communities by viewing their holistic needs and supporting them to be more resilient against a variety of risk factors. Villagers are guided to research, analyze, plan and implement action plans they feel will support their village community economically, medically and emotionally; CARE has supported these efforts by monitoring activities in villages and providing small grants that will result in empowerment and increased cooperation among villagers. CARE has also supported the use of peer educators to mitigate the impact of HIV/AIDS; trained CBDs to increase the reach of socially marketed dual protection methods and pills, and trained TBAs and linked them with midwives. CARE plans to expand successfully piloted interventions such as postpartum distribution of Vitamin A and iron by TBAs, Health Center based equity funds for deliveries, community support systems for transportation of obstetric emergencies, and motherhouses. CARE uses existing partnerships and strengths of Khmer culture by supporting Buddhist monks and Muslim Imams to provide community care, counseling, support and education.[9]

Behavior Change Activities

CARE's behavior change activities include their work with promoting reproductive and sexual health in Phnom Penh which targets > 50,000 garment factory workers; work with the Reproductive Health Association of Cambodia (RHAC), work in collaboration with the Municipal Health Department and others in developing the technical and communication skills of factory based health providers; peer education and training IEC/BCC activities include a) life skill peer education in factories; b) a workplace advocacy program that sensitizes factory management to the issues of access to

[7] CARE-USAID Narrative Workplan Fiscal Year 2005, pg.1
[8] Ibid, pg. 2-3
[9] Ibid, pg 3-5.

health services and education; and c) a casino worker BCC program which reaches casino workers with health information, referrals and support; which has the capability of reaching over 3000 young people.[10]

Budget/staffing information: In reviewing CARE's workplan for 2004-2005 it states that the health sector coordinator and technical advisors are on CARE/Australia or CARE/Cambodia contracts. All national staff are employed through CARE/Cambodia.[11]

Interview with CARE staff on 4/25/05:

The public sector currently is seen as a place where private providers obtain their patients through referral from other private providers working in the public sector. CARE is concerned about the protocols around abortion and how government employed personnel will be able to deliver these services.

Currently, CARE with USAID funding is working on government policies re: incomplete abortion. Their services come under the senior management and administration of the Provincial Health Department. CARE is providing assistance to the PHD in systems strengthening. The PHD under their management umbrella could bring in IPAS or others on contract to integrate abortion services into the health system. Questions posed by the CARE staff included:

1. How can they address illegal, incomplete abortion while remaining in compliance with the Mexico City Policy as they provide management services on behalf of the government to the health centers; and
2. How can they comply with the minimal package of activities and the comprehensive package activities?
3. How does one set up a system where abortion is legal and still be able to deliver the terms of its contract in an environment wherein other actors are providing the abortion services?
4. How do you provide management of government facilities without violating the Mexico City Policy?

There was discussion regarding the legal umbrella in which CARE employees are working in Cambodia. The MAARD providing funding from USAID to CARE was provided to CARE International located in Atlanta Georgia. However the staff in Cambodia is representing CARE/Australia and CARE/Cambodia. At the time of the meeting, there was no documentation available that provided a clear understanding of the relationship of CARE/Australia and CARE/Cambodia to CARE International.

Ms. Curtis made the following suggestions to CARE with the understanding that final guidance would be provided by Barbara Seligman when she visits Cambodia in June, 2005.
1. Look at services that CARE can provide that will not put them at risk of violating Mexico City Policy while still contributing to reducing maternal mortality and morbidity and increasing the quality of services. See recommendations below. It was recommended that they write out any further questions that they may have for Barbara. It was recommended that CARE provide documentation re: the legal standing of CARE/Cambodia, for Barbara's visit. in June wherein these questions/issues can be more fully addressed.

Assessment:
Mexico City Policy/Helms Amendment Issues:
1. The MAARD from USAID/Cambodia was provided to CARE International, a US based NGO. However, the staff in Cambodia is on contract with CARE/Australia and CARE/Cambodia. The funding stream from CARE International to CARE/Cambodia and CARE/Australia is not clear.
2. Due to a recent contract that CARE/Cambodia has entered into with the MOH, it is unclear as to whether their activities will violate any portion of the Mexico City Policy or Helms Amendment.

Postabortion Care:
Care has:
1. Expertise in VCCT/PMTCT and STI training
2. Ready networks for introducing IEC/BCC information regarding postabortion care; i.e. Monks, youth, factory workers; community resilience programs; casino workers, etc. This provides new audiences for introducing information on postabortion care; need for family planning, and complications related to miscarriage and unsafe abortion.

[10] Ibid, pg. 6
[11] CARE-USAID Narrative Workplan, Fiscal Year 2005; Budget Notes – USAID Submission Oct 04 to Sept 05

3. Expertise in doing facilitative supervision and use of COPE for quality improvement.
4. Expertise in working at the national policy level to effect change.

Recommendation for implementation of postabortion care
Mexico City Policy/Helms Amendment Issues – Recommendations were made to CARE as follows:
1. Obtain documentation that shows the relationship between CARE International and CARE/Cambodia. This will provide clarity re: funding for CARE/Cambodia staff and their level of accountability to the Mexico City Policy.
2. Provide copy of the contractual arrangement with CARE and MOH for this most recent contract to determine their management role and to identify any areas that may present opportunity for violations of the Mexico City Policy
3. Document further questions so that they can be addressed by Barbara Seligman during her visit in June, 2005.

Postabortion Care Programmatic Interventions
CARE can assist in the scale-up of postabortion care programs in the following ways:
PAC Component One - Emergency treatment for women experiencing postabortion care
Care can:
1. Participate in the development of national policy on postabortion care separately from the comprehensive abortion care policy.
2. Participate in the development of a national curriculum for postabortion care and national service delivery guidelines for PAC
3. Begin to prepare sites for doing postabortion care where comprehensive abortion services will be provided by preparing a different space for postabortion care that will be physically separated from planned abortion services in all government health facilities managed by CARE.
5. Assist in developing selected sites for clinical training sites for postabortion care training
6. Participate in policy development that will ensure availability of pain medication for emergency treatment
7. Assist the MOH in integrating indicators for postabortion care in its MIS system

PAC Component Two – FP counseling and service delivery; STI Evaluation and treatment; HIV counseling and/or referral for testing
CARE can:
1. Assist the health centers in reorganizing FP services (i.e. rearranging services so that FP counseling and service provision are in the same location as PAC emergency treatment services regardless of MVA or D&C).
2. Work to ensure drug, equipment, FP commodities for PAC programs.
3. Position VCCT sites or VCCT at postabortion care sites for easy referral of PAC clients to HIV testing.
4. Assist in repositioning services for STI evaluation and treatment so that they are provided at the same time of emergency treatment.
5. Strengthen the supervision of PAC services through facilitative supervision. It will be important to have different personnel supervising PAC services than those who provide supervision for comprehensive abortion services.
6. Identify problems and increase the quality of services by using COPE for quality improvement.
7. Work with CBD workers to be partnered with TBAs and midwives to enable the delivery of family planning commodities in communities and villages

PAC Component Three – Community Empowerment via community awareness and mobilization
CARE can:
1. Integrate messages regarding unsafe abortion; prevention of unplanned pregnancy/abortion by use of family planning; emergency transport and establishment of emergency funds for obstetric emergencies in activities in the many community networks that CARE has established. Audiences for these messages would include garment factory workers; monks; WAT grannies; community resilience activities;
2. Educate peer educators on postabortion care to reach all the populations i.e. Couple in the Know program; sex workers; uniformed service; peer educators.
3. Evaluate the usefulness of the PAC community mobilization activity that was carried out in Bolivia for its applicability to CARE's BCC programs.

Reproductive Health Association of Cambodia (RHAC)
Persons contacted: Dr. Ping Chutema, Director of Clinical Services
Vong Davy

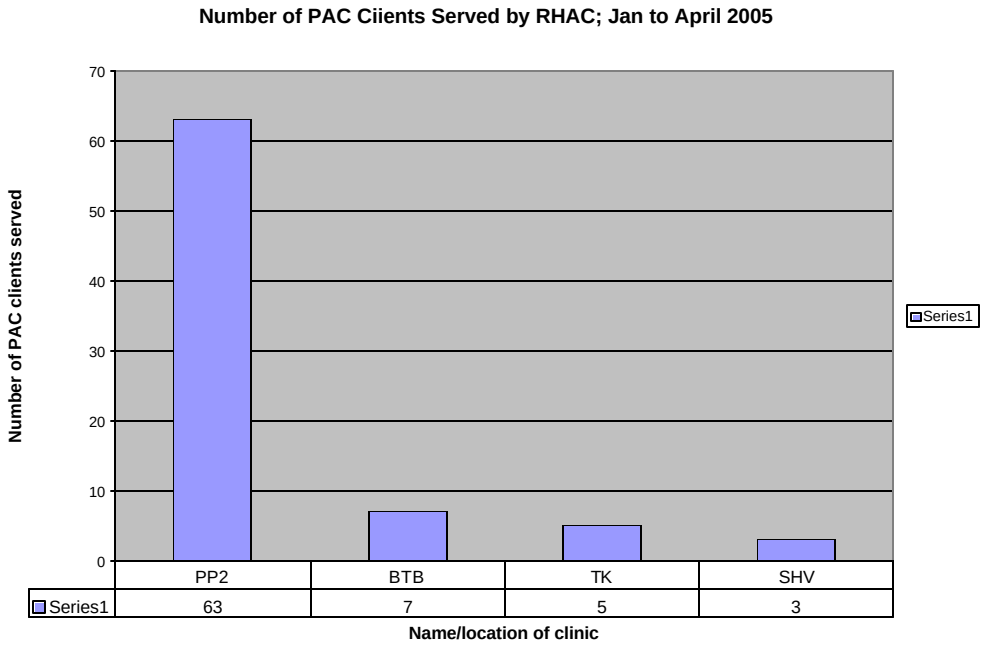
Overview
An overview of country statistics was given by Dr. Chutema. She noted that maternal mortality rate is high with abortion related deaths as the major complication of abortions. There is a low CPR rate and PAC services are limited throughout the country. RHAC is known as having quality comprehensive reproductive health services. They have a potential volunteer network through different groups including youth, young entertainers; fishermen. RHAC has 3500 client visits per month and sees 501 OB patients per month. Some of the services provided at RHAC include obstetrical care services; STI evaluation and treatment; HIV counseling and testing; PMTCT services; pap smears, and male services. Male services include STI evaluation and treatment; HIV counseling and testing; infertility, and vasectomy services. The lab has the ability to do testing for HIV, gram stain; pregnancy testing; Hgb, urinalysis; hepatitis; Type and RH; and RPR. Hours of operation are 7:30 AM to 5:00 PM Monday through Saturday.

Postabortion Care Services
Postabortion care services were started at RHAC in 2004. Currently they have five centers providing PAC services with plans to expand to two more clinics. Some plans for expansion include; training selected midwifery staff to be PAC providers; equipping seven sites for postabortion care services; providing promotion through RHACs existing network and clients; and developing a postabortion care booklet together with RACHA. [12]

Currently they have a provider manual for postabortion care services in place. This manual was developed from RACHA's materials. MVA kits are currently available for providers. All providers are made aware of the Mexico City Policy and know the definition of abortion. Clients provide informed consent before postabortion care procedures are done. Counseling on birth-spacing methods is provided after emergency treatment and a computerized record is maintained on all postabortion care clients. Statistics for postabortion care clients seen at the four sites from January 2005 to April 2005 are as follows:

[12] Chutema, P. RHAC PAC Services, - Presentation made by to USAID PAC Team on April 27, 2005.

Figure 1



Reasons that patients present for PAC services included medical abortion (47 patients) wherein the patient presents with bleeding one to two weeks after incomplete abortion; spontaneous abortion (11 patients); accident (9 patients); and incomplete abortion (7 patients)[13] (i.e. during our visit in Cambodia, we were told that many women obtain medication from the pharmacy to induce abortion and then present for PAC services once bleeding has initiated. This appears to be the explanation for the medical abortion" as noted in the above statistics.) Women greater than 12 weeks gestation and those with infected incomplete abortions are referred to the National Maternal and Child Health Center (NMCHC) for PAC services. In severe cases, the woman is transported by car with the transport time being approximately 15 minutes. Less than 1% of the PAC cases have been transferred. The challenge in transfer is that they do not have an ambulance

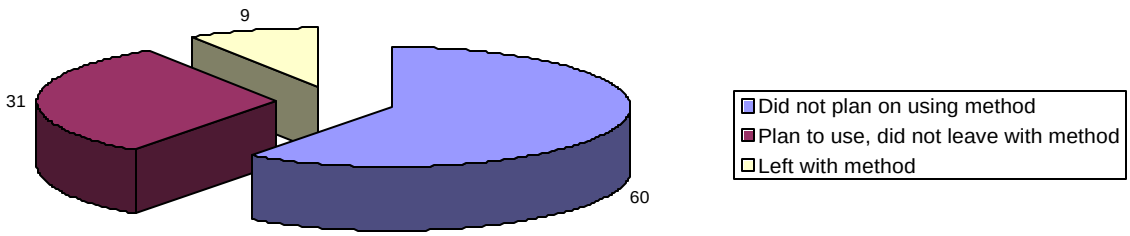
Management of postabortion care clients includes history and examination. Pain management is provided after the procedure with oral ibuprofen 400mg every 8 hours for 5 days. Prophylactic antibiotics are given for 7 days post procedure. Antibiotics are available on site at no additional charge to the woman. A follow-up visit is scheduled in 7 days post emergency treatment. All women receive oxytocin as a part of emergency treatment. Women are counseled on warning signs of post procedure complications and when to return to the facility should complications arise. The main reproductive health intervention requested by women is Pap smear screening. STI and HIV counseling and testing are available at RHAC. They are also interested in linking PAC services with their HIV and STI services. Ten women who have received PAC services have been referred for VCT.

Contraceptive use following emergency treatment:
While 100% of clients presenting for postabortion care services received counseling following emergency treatment; only 31% of women stated that they intended to use a method in the future, and only 9% of women were discharged from the facility with a method. Sixty percent of the women did not choose to use a method as they desired to become pregnant again.[14] (See Figure 2) Contraceptive methods available include oral contraceptives; injectables; IUD; Norplant and vasectomy.

Figure 2.

[13] Ibid.
[14] Ibid.

**Contraceptive use for RHAC PAC Clients after emergency treatment;
Jan to April, 2005**



RHAC provides male services which include STI evaluation and treatment; HIV counseling and testing; vasectomy, and infertility. Currently the men are not included in the FP counseling session when they accompany their partners to the health facility for PAC services.

Tiahart amendment posters were visible in the patient areas and the counseling areas. All areas were clean, had evidence of practice of infection control techniques.

Training for Postabortion Care services

RACHA obtained training from EngenderHealth in postabortion care. They have provided PAC training to four RHAC providers. The curriculum used by RACHA is a combination of curriculum from varied sources. Dr. Chutema is concerned about the competency of the staff's clinical skills as they only practiced on models and did not have clinical observation or clinical training with patients.

Dr. Chutema felt that a minimum of five cases is needed to feel comfortable with hand skills. Her desire is to have a supervisor come to validate their clinical skills. It is felt that TA is needed to conduct PAC assessment and analysis. Review of the training curriculum was done and is found in appendix H.

Compliance with Mexico City Policy

It is stated that the center does not perform abortion services or any other activities that may violate Mexico City Policy. The staff has received information on the Mexico City Policy and their providers are in agreement with this policy. See appendix B for review of compliance with Mexico City Policy.

Review of RHAC Clinical Protocols

The clinical protocols for RHAC were dated January 2003. They were very comprehensive for contraception; management of STIs; management of selected gynecologic problems such as endometriosis; menstrual disorders; PID, cervical cancer; ovarian masses; and emergency medicine. The protocol for antenatal care discussed normal pregnancy complaints; diseases of pregnancy and risk factors for these diseases. Under the topic of hemorrhage; evaluation for unsafe incomplete abortion was not included but could be easily inserted. While there was a listing of contraceptive method and their effectiveness rate on page 10; female condom lactational amenorrhea method (LAM) and standard days method (SDM) were not included in the listing, however the calendar method which is not an effective modern method was included. Improvements to the clinical protocols would include references throughout the document to note where the cited management can be found in clinical literature; a complete reference listing which would include

the date of the publication being cited; date and signature to indicate how often the protocols are reviewed and updated; and name of the person(s) who reviewed and approved/authorized the clinical guidelines for staff use. Usually this review would occur every one to two years.

Challenges identified by RHAC

The challenges identified by RHAC include the fact that they have theoretical learning, but not practical clinical training. They have not been able to identify a training course for their newly established PAC service and have not identified the necessary technical assistance needed for their PAC program.

Overall desires of the RHAC PAC program include:

1. Training 3 CMs and 7 midwives.
2. Technical assistance to conduct an assessment and analysis of their PAC program to improve the quality of the services and to ensure compliance with the Mexico City Policy. The also want this assessment/analysis to include income generation; a quality model for the delivery of PAC service; a good M&E system and a data base for PAC.
3. Technical assistance to review the existing protocols and develop specific checklists for quality PAC care.
4. Supervision of their clinical service is desired
5. Promotion of PAC services in the community.

Assessment:

1. RHAC appears to be well organized with a variety of services that are appropriate for integration into postabortion care services.
2. The staff is aware of Mexico City Policy and desires to be in compliance with it.
3. The statistical data re: PAC cases received indicate that many women seen for postabortion care services are possibly self-aborting by use of medications obtained from the pharmacy to induce bleeding, thus prompting their need for postabortion care services.
4. The staff is concerned about the safety and correctness of their clinical skills

Areas of Strength:

1. PP2 site has the capability of being a training site for PAC clinical training due to the numbers of patients seen during the first 4 months of 2005.
2. STI/HIV services are readily available in the site
3. The staff has the desire to provide quality PAC services due to their request to have clinical supervision of their skills
4. The staff had the desire to do evidence based programming via interpretation/assessment of their clinical data
5. There is a referral mechanism in place for receiving clients from outside referrals as well as referring clients to higher levels of care.
6. There is a 2nd visit for PAC services which can allow for evaluation after emergency treatment and increased uptake of family planning methods
7. There is a network in place through which PAC community mobilization activities can be implemented.
8. The presence of clinical protocols for patient management.

Areas to be strengthened:

1. While 100% of patients receive family planning counseling, only 9% are leaving the facility with a family planning method. There is the need to investigate with staff and with patients how family planning counseling and service delivery can be improved.
2. The lack of clinical training for emergency treatment is problematic for the program. The quality of the clinical services cannot be ascertained due to lack of testing of clinical skills and ongoing clinical supervision
3. There is need for a standardized curriculum which will allow for testing of both theoretical and clinical knowledge and skills. This would also include counseling skills.
4. RHAC Clinical protocols need to include management of complications related to miscarriage and incomplete abortion.

Recommendations:

1. Establish PP2 as a clinical training site for RHAC PAC providers. This will include identifying staff that will become the master trainers for PAC. These individuals may need to go outside of Cambodia to obtain the necessary clinical experience needed to refine their present MVA clinical skills.

2. A standardized PAC curriculum for Cambodia should be established that will provide for theoretical and clinical testing of all potential PAC providers. The recommended passing score for the theoretical and clinical skills should be a minimum of 85%.
3. To ensure quality PAC services as well as provide reassurance to current PAC providers, all providers who have been trained should be tested on their theoretical and clinical knowledge and skills for PAC. The minimum passing scores should be 85%. Providers who are able to score 85% on the theoretical knowledge can then go on to be tested in clinical skills. Providers who are not able to obtain this score could be tested again; those not passing should no longer be able to provide services in the areas in which they did not receive a passing score of 85%.
4. Before initiating PAC services in any further sites, need to strengthen the quality of PAC services and build up patient caseloads in the sites where PAC is currently being provided. Establishment of a quality clinical service delivery site is needed before providing clinical training to additional providers. While emergency treatment services may not be provided in new sites, these sites can be prepared for PAC services by beginning the process of reorganizing family planning counseling and service delivery to occur at the same time and location as planned emergency treatment. Community mobilization messages regarding complications due to postabortion care and the need for family planning can be initiated in these areas.
5. Standardized clinical service delivery guidelines and standard protocols need to be established at all PAC sites.

Reproductive and Child Health Alliance (RACHA):

Persons Contacted: Theary Chan, Executive Director

Background:

RACHA was formed by USAID in 1996 and became a Cambodian NGO in 2003. Funding from RACHA is from varied resources which include USAID, Packard foundation; Pfizer; Anonymous donors via EngenderHealth, however 90% of its funding is from USAID. In 2004, they also received a small grant from the CATALYST consortium funded by USAID to do a postabortion care community outreach program. RACHA works with the Ministry of Health and has coverage in 5 provinces; 5 Operational Districts (ODs); 5 Regional hospitals; 115 Health centers; 196 communities; and 1597 villages.

Activities:

The goal for RACHA is to increase reproductive and child health and to reduce the prevalence of HIV/AIDS. Safe Motherhood is the main instrument used in providing training in life saving skills and neonatal resuscitation. Since 1999, they have trained 500 midwives. RACHA also does EOC, PAC, syphilis screening, birth spacing using modern contraceptive methods and VSC. They dispense home birth kits though UNICEF. Currently they are not doing Vitamin A for postpartum mothers, but plan to do so in the future.

RACHA provides training to surgeons for VSC services; VSC is now available in 24 referral hospitals. Syphilis testing is available in 14 centers with STIs being managed using a syndromic approach. VCT and PMTCT services are also provided. RACHA's goal is to integrate STD and HIV/AIDS into reproductive health services nationwide. Outreach activities include working with rural migrant couples and comedy for BCC.

Capacity building is achieved by using COPE to address logistics. They are also involved in micro-credit schemes; work with village shops; health promotion through VHCGs; monks, nurses, and WAT grannies, and community performance contracts.

Postabortion Care Activities.

Objectives for RACHA for PAC are to increase knowledge and understanding of the community and to increase the use of high quality PAC services. From October 2003 through March 2005, RACHA has trained 55 care providers; 268 TBAs; and 625 VHCGs. Postabortion care services are being provided at six hospitals and 25 health centers. Since October, 2003, 433 clients have received PAC services with 90% of emergency treatment being done by MVA and 10% by using curettage and manual removal. It was stated that 100% of patients receive counseling with 26% of clients accepting a FP method prior to discharge from the facility. Twenty four percent (24%) of PAC patients have been referred for other RH services. Follow-up postabortion care visits are done through the midwife and TBA; if there is the need for pp f/u; it is; done within one week of PAC by the TBAs. TBAs are only able to advise on family planning methods; they are not able to dispense methods. Community based distributors (CBDs) are able to dispense pills and condoms. There is the need to look at how to link midwives with CBDs.

RACHA Workplan activities related to PAC 2004-2005

- **Improve and Expand safe motherhood services by**
  - **developing and integrating PAC into the Life Saving Skills (LSS) curriculum**
  - **conducting TOT on PAC to existing LSS trainers both at national and provincial levels**
  - **training midwives to recognize and treat postabortion care complications;**
  - **strengthen referral to appropriate health facilities**

- **Improve and expand Birth Spacing and Limiting Services by:**
  - **training health center midwives in RH, including counseling and provision of services (pills, condoms, etc)**
  - **conducting training and f/u to care providers in clinics**
  - **collaborate with MOH to update VSC, IUD, EC and publish**
  - **help the MOH to expand coverage of and accessibility to VCT and PMTCT services in accordance with NCHADS national plan**

Mexico City Policy:
Ms. Chan expressed concerns about RACHA's compliance with Mexico City Policy. She stated that they have informed all the midwives trained about the Mexico City Policy and given them clear instruction that the MVA equipment is not to be used for abortion services. Ms Chan stated that the midwives had no problem with this policy; however she remains concerned about what to do should any midwife use the MVA equipment for performing abortions. Ms. Chan was informed by Ms. Curtis that since RACHA staff was not providing services, their technical assistance for PAC training did not put them at risk of inadvertently violating the Mexico City Policy. In addition, once the MOH staff was trained, RACHA is not responsible for how the MOH assigned staff duties.

Observations of RACHA's activities included site visits to the Red Cross Hospital; the Siam Reap Provincial Health Directorate; the Siam Reap Operational District, the Pouk Health Center. observation of two village teaching sessions regarding postabortion care; review of the curriculum and service delivery guidelines for postabortion care. Assessment and recommendations will be provided after the discussion of each facility with an overall summary of findings and recommendations for RACHA provided at the end of the section on RACHA services.

The Red Cross Hospital:
Person(s) Contacted – Dr. Nhep Angkeabos; Sok Somali
Background:
The Red Cross Hospital is a 24 bed government facility which covers a population of 250,000. They have 56 staff consisting of physicians, medical assistants; midwives; nurses; pharmacists; and lab techs. Services provided at the Red Cross include ANC which is the minimum package of activities (MPA), namely basic essential obstetric care or obstetric first aid; family planning services; STI services; HIV services and Vasectomy services. They are just beginning to provide PMTCT services. Caseload statistics include the following:

Service	Number per month
ANC	700 to 800
New OB	300
Deliveries	150
Family Planning- total	50-60
Family Planning – new	5 to 6
STI visits	300 to 400
PMTCT just starting	anticipate 100-150

The Red Cross Hospital works with RACHA for training. The midwives come to the hospital from varied provinces for training that lasts two to three weeks. The Red Cross is one of two sites for LSS training with the trainers rotating between these two sites. PAC is a new training course with 100 midwives trained since 2003. In 2004, 42 midwives were trained; so far in 2005, 18 have been trained. The RACHA 4 day training emphasizes uterine evacuation with MVA where appropriate, counseling and communication, and provision of Birth Spacing counseling services; RTI screening, counseling, and referral consistent with MOH training materials.

D&C skills are not included in PAC training of midwives since it is not within their scope of practice. However, often the midwives may use curettage to ensure total uterine evacuation after completing the MVA procedure.

There are three other centers under this OD that are providing PAC services without training. There is a plan to give training in the other 3 centers by the end of the year depending on time and availability of funding. Due to stigmatization, it is very difficult to get information on private PAC services as there is a tendency to hide the statistics.

Care for postabortion clients:
Pain management is done for emergency treatment sometimes using atropine or diazepam based upon the client's condition. Usually these medications are administered IM. Ibuprofen is not available. Clients may stay in the hospital up to 3 hours post emergency treatment. They are provided information re: warning signs for complications that may occur within 15 days after emergency treatment. Every client receives family planning counseling with referral to another area in the hospital for FP methods. Approximately 50% of the clients are sent to FP services; but there is no system to track if the patient actually went for FP methods. FP methods available include IUD, condom, pill, Depo-Provera; Norplant is not available. When asked about STI prevalence among PAC patients, one midwife suggested that 90% of the patients she saw needed referral for STI evaluation/treatment.

Suggestions for USAID included continuance of support for refresher training in PAC; support is needed by the Red Cross for set-up and follow/up system to evaluate performance of training; and support is needed to secure MVA equipment.

Assessment:
1. The Red Cross Hospital has a busy obstetrical service however while there are 150 births per month, there are only 50 to 60 total family planning visits per month representing 33% to 40% of postpartum women coming for a family planning visit.
2. The midwifery staff report that STI treatment needs are great (90%) among PAC patients.
3. The Red Cross Hospital serves an important role as one of two training sites for nurses and midwives
4. The midwives are uncertain about their MVA skills as they use curettage after MVA treatment to ensure uterine evacuation.

Areas of strength:
The Red Cross Hospital:
1. Has a busy antenatal service
2. Has the infrastructure in place for PMTCT and STI evaluation
3. Has a good method mix of contraceptives available in the hospital setting
4. Provides pain medication as needed to clients for emergency treatment

Areas needing strengthening:
1. There are only 5 to 6 new FP cases per month; this represents approximately 3% of the number of women who deliver
2. There is no tracking system in place to monitor referrals to the FP clinic that occur after FP counseling.
3. There is a lack of clinical training for MVA skills. Due to this, there appears to be lack of confidence in MVA skills as curettage is used to ensure complete uterine evacuation. This results in use of two technologies to complete uterine evacuation which is an additional expense to the hospital
4. It is uncertain if there has been whole site training regarding PAC. This would include orientation to supervisors and hospital administration on postabortion care and the need to reorganize location of services to ensure ability for clients to receive fp method in same place as emergency treatment
5. There are no clinical checklists seen with the RACHA curriculum that would identify necessary steps in providing postabortion care services or demonstrate competency in skills attainment
6. There is no evidence of pre and post test examination to evaluate the theoretical knowledge of the trainee.

Recommendations:
1. It is recommended that ACQUIRE determine whether orientation of all hospital administration/supervisors to PAC services has occurred. This will allow for better understanding of the PAC program and support for services/commodities needed for PAC.
2. Whole site training may be needed for postabortion care.
3. ACQUIRE will need to assist RACHA in helping the MOH to reorganizing services so that family planning counseling and service delivery can occur in the same place and at the same time that PAC emergency treatment occurs. FP methods will need to be relocated to the location of PAC emergency treatment.
4. RACHA should consider training all GYN and OB ward staff in family planning counseling. This will allow a family planning counselor to always be available for the PAC and postpartum patients.
5. ACQUIRE needs to assist RACHA in developing an ongoing supervision system so that transfer of learned of quality PAC skills to the workplace is ensured.
6. ACQUIRE needs to assist RACHA in updating the curriculum so that clinical skills checklists for all skills necessary to carry out PAC services; i.e. counseling skills, MVA skills; FP provision. These items are included.
7. ACQUIRE needs to assist RACHA in developing pre and post test examination in postabortion care is needed to measure theoretical knowledge base for PAC if this is not already included in the curriculum.

RACHA – Use of IEC/BCC materials from Draft Global PAC Resource Package
Persons Contacted: Ms Theary Chan, Executive Director; Mr. Mom Sochinda, RACHA IEC/BCC team leader; Ms. Sun Nasy – Deputy executive director; Ms. Krouy Kim Houn – RHAC IEC/BCC team leader; Dr. Charya Hen – OPH/USAID/Cambodia

Mr. Sochinda presented the findings related to the review of the Global PAC Resource package. Translation for all materials was not available at the time that the team reviewed the Global PAC Resource package. Now that all the translations are now available, the IEC/BCC team from USAID/Cambodia, RACHA and RHAC will review the package again to see if there are other materials that can be used.

Upon review of the PAC Global Resource package IEC/BCC section, three tools have been chosen thus far for adaptation. It should also be noted that the samples selected were not the ones from the "recommended" list. However selected materials enhanced the materials RACHA was already using. Chosen tools included Community postabortion care; Men as partners; Family Planning Counseling Kit; Are You at Risk; and When to begin FP method after pregnancy. IEC/BCC materials adapted from these tools include:

(a) A model poster for family planning methods for use in postpartum and postabortion care with messages for men; will use the image of a couple on the poster; will field test for acceptability of use with clients and service providers; and will include a list of available methods that can be used immediately

(b) a sample male involvement brochure using "Men as Partners" and modified to the local setting;

(c) A sample PAC client brochure to include messages about avoiding heavy work and the specified timing for recuperation, warning signs, and postabortion self care instructions. The IEC/BCC team will also use the video tape – Put yourself in her shoes. Three of these materials had been adapted to Khmer audience since April 19, 2005. We also reviewed the DVD for counseling on PAC. Copies of the DVD were made for further review. It is desired that we obtain the script for the DVD so that this can be adapted to the Cambodia context. As per my conversation with Mr. Sochinda, he stated that use of the Global PAC Resource Package has saved them much time in producing IEC/BCC materials as they can choose which material they would like to adapt and do so in accordance with the Cambodia context.

Assessment:
1. The Global PAC Resource Package has been useful in USAID/Cambodia's PAC program by providing IEC/BCC materials that are ready for adaptation.
2. The Global PAC Resource Package does not have materials for mass media. This is a gap in the materials presented.

Areas that need strengthening:
1. USAID needs to identify resources on PAC for use in the mass media.

Siem Reap Provincial Health Directorate

Person Contacted: Dr. Dy Bun Chhem, Ph. D., Director
Background:
The Siam Reap operational district has12 administrative districts; 4 operational districts (ODs); 100 communities; 53 health centers with plans to build 7 more health centers. The total population served is > 800,000. The three operational districts have increased to 4 operational districts as one district was divided due to population size; but the PAC program operates in the same number of health facilities. Two health centers are not staffed at the recommended level for MPA. Since the beginning of the program, there have been 69 PAC clients served in the OD. In the first three months of 2005, they have seen a total of 36 clients.

According to the director, the Cambodia situation reflects a problem with ANC; survival overshadows positive health-seeking behavior and women are perceived as not knowing how to care for themselves resulting in heavy workloads and increased spontaneous abortions.

Most health centers do not have midwives who can provide PAC services due to very low salaries (midwives earn the equivalent of $10/month and physicians earn $45/month; private sector salaries range between $50 and $200/month). There is a plan to upgrade the health systems but salaries are still low. From 1999 to 2004, Belgium NGOs provided salary supplements for good performance incentives. Beginning in 2005, BTC aims to cover 90% of all health centers and 100% salary supplementation for the next four years.

Income from the health centers is from the user's fee and the MOH salary. The government has decreed that user's fees be divided into three categories: 50% goes for operational costs of which 5% goes to the OD; 49% goes to health center staff; and 1% is returned to the government. Government funding often comes in late. To date 30% of the 2004 budget has not been obligated, therefore the user fees are critical to maintain and sustain the operation of the health center. The BTC supports equity schemes in referral hospitals and in five health centers which assist in the payment of user fees for the poor.

Staffing continues to be problematic. Optimal health center staffing should be at 800 but it is currently 600 with 200 lost staff including midwives and physicians. The OD director has asked for 30 more midwives last year—five were approved but it is still not clear that these 5 will arrive. Health centers are supposed to provide services 24-hours per day, seven days per week but do not always do so.

Health Sector Reform

Health sector reform occurred in 1996 by addressing the lack of confidence in services voiced by residents surrounding one health center in Siam Reap. The residents worked with the village leader to see how to increase the quality of services. The discussions progressed to the Siam Reap health committee. Based on this model, in 2003, a national policy for community participation was developed.

Prior to health sector reform there was one infirmary for each community. There was supposed to be 53 health centers, however only 5 of the buildings were being used as infirmaries resulting in a deficiency of 48 buildings as they needed to have 53 health centers. Problems included lack of staff, equipment and drugs. An assessment was conducted with findings indicating that the health centers needed to be reformed. As a result of the assessment and reforms, in 2001, the MOH had the necessary 53 buildings functioning; Each center had an increased ability to provide drugs, supplies and staffing to serve a population of 8,000 to 12,000. Community participation is seen as a vital part of the increasing utilization of services. In 1997, a minimum package of act ivies was introduced into the health centers as a result of community participation

Trained government providers conduct one-third of deliveries, with one-third conducted at the Swiss hospital, including PMTCT services; and one-third conducted by TBAs. TBAs have limited knowledge about handling complications of incomplete abortion thus orienting TBAs about danger signs and referral could be an important element of increasing women's timely access to services. PAC trainers, service providers, VHSGs, and TBAs increase the community's preparedness and support mobilization of clients from home to facilities. The PAC program trains health providers, TBAs, and VHSGs and is seen as a good approach to increase community awareness, and mobilization for referral to the clinic on time. Dr. Chhem recommended that USAID continue PAC training for other geographical areas.

Relationship with RACHA:

From 1994 to 2003; UNICEF wanted to train TBAs. However, the impact of TBA training on overall health was not great; therefore UNICEF chose to discontinue their training. In 1997 RACHA began providing TBAs with Home Birth Kits and training on clean delivery for neonatal tetanus prevention as a strategy to address the 13% neonatal death rate from tetanus. RACHA had success in Siem Reap using the home birth kits to support hygiene, infection prevention, and practices to reduce the risk of HIV transmission. RACHA was asked to conduct a follow-up study with the neonatal tetanus activities.

With a small grant from CATALYST, in September 2004, RACHA began community outreach activities. These activities provided training and information to village volunteers and TBAs about available PAC services (dangers of unsafe abortion, warning signs of complications of abortion– either spontaneous or induced, ability of health center staff to effectively manage many of these complications, and availability and benefits of birth spacing methods at the health center) and began support for referral to the local health center. This activity has helped TBAs recognize signs of postabortion complications and reduce the number of TBA-induced abortions. Due to this activity it is thought that there has been a remarkable change among TBAs. The number of PAC referrals are increasing and the number of abortions by TBAs is decreasing. Verification of changed TBA practices was reflected in the reduced number of severe postabortion complications. They are now seeing more spontaneous abortions. To date the program has paid transportation costs for 4 persons since the start of the program in September, 2004.

Postabortion family planning is provided in Siem Reap after uterine evacuation. Culturally, women are not ready to initiate family planning immediately after a pregnancy loss. Providers state that approximately 50% of women return for FP methods while 50% does not. Pills and injectable are the most often requested methods.

In June 2004 PAC training of midwives was started and in August and September 2004, training of TBAs was conducted.

Safe Abortion Services:

Currently, none of the health centers are providing safe abortion services. Although the declaration has been delivered, there is still the need for clear guidance form the MOH. Guidelines are needed for this. . There are no records kept regarding how midwives support the system. Safe abortion services may be available from private providers.

Assessment:

1. Safe abortion services have not been initiated due to the lack of standard guidelines for implementation of this service
2. While family planning is provided as a part of PAC services, cultural influences affect women's decision to accept a method of birth spacing
3. The PAC community awareness program is seen favorably in its role of increasing referrals to health facilities for PAC services
4. The role of the community is valued in its role of promoting change in quality of services
5. Staffing levels affect the ability to provide all types of services.
6. TBAs have a major role in the performance of deliveries and other services.

Siem Reap Operational District (Mondul Muy Health Center)

A meeting was conducted with the director and deputy director of the Siem Reap Operational district. The discussion focused on the RACHA supported PAC community orientation activity and referral for PAC services. In 2004, service provider (midwives) training was initiated with training follow-up scheduled on a monthly basis. Since September 2004, PAC-orientations have been conducted for 129 TBAs and 225 VHSGs. Community participation is seen as being "low and passive". There was the expectation that there would be more PAC cases seen in the hospitals, but few clients have come for these services. RACHA has provided training to TBAs and VHSGs to provide health education to the villages with midwives providing follow-up of TBA's and VHSG's knowledge. Health education sessions cover signs and symptoms of incomplete abortion and transportation fee coverage to support timely access to care.

A variety of topics are covered every 2-3 months by the VHSG conducting village meetings. Health educations session are on a regular basis, but it depends on the VHSG and TBAs covering the village.
The expected function of the TBA and VHSG after completion of the PAC orientation was discussed. The expectations of their function were not clearly delineated. The TBAs and VHSGs are to provide health promotion to the village during their free time. When complications arise, they refer the women to the health center. Often the TBA may be functioning as a member of the Village Health Support Group. The health center is only open 4 hours in the AM and is responsible to do health education in the villages in the afternoon. After the morning hours the midwife is on call. Therefore, although the TBAs and VHSGs add PAC to existing health education functions, low use of facilities may be a result of non-availability of trained staff the health centers where clients would go (primary midwives have no PAC skills and they most often are at the centers; secondary midwives with the skills may not be on site), therefore, clients seek care from private provider and from TBAs who may available. Issues of confidentiality may also contribute to the women's use of private providers.

Recordkeeping of activities by district staff is conducted through the collection of statistics at monthly meetings with the health center chief and by spot-checks by supervisors.

The impression of the PAC Community Awareness Program is that the outreach program is relatively new and of has only been available since September 2004. There are low staff numbers; more secondary midwives need to be trained to provide PAC services. If primary midwives and nurses were trained within PAC constellation of services, it could increase the coverage of women. Geographical coverage is a challenge and an increase in the number of staff who could provide PAC services would help to increase coverage.

Even though there is reimbursement for transportation fees, the cost of services remains a barrier. The existing transport fees are affordable for women in the area, but user fees vary considerably. Referral hospital user's fees are higher (quoted at $25) than the health center's fees ($1 – 5) and some women refuse to go. BTC's equity scheme[15] helps to cover those women who cannot afford services at the referral hospital. It should be noted that if costs at the referral hospital ($1.25 - $12.50) were equal to those of the private providers, women would opt to go to the private providers. Private fees are approximately $25 and $20-30 for abortion procedures on gestations less than 8 week and $100 for abortion procedures on gestations greater than 8 weeks. Any price can be named for management of abortion complications.

Stigma related to abortion remains a problem, therefore women--especially married women--prefer private providers who will be discrete. However these providers may not be competent. Staff at this meeting felt that the private providers were more interested in income generation than in safe practices. In the presence of stigma, how much can be discussed in the community? Staff felt it was not difficult to discuss in the health education talks by TBAs.

Some members of the VHSGs are TBAs so they are able to provide some methods. In addition, community-based agents provide condoms and pills within the community.

Assessment:

[15] Belgian Technical Consortium is providing an Equity Fund on a pilot basis, which supports salaries and a sliding fee/cost recovery program in 2 referral hospitals and 5 health centers.

1. There was an anticipation of higher client numbers at the health facilities after the community was provided with education on danger signs and complications related to miscarriage and unsafe abortion
2. It is expected that TBAs and VHSGs would provide referrals and education during their free time.
3. It is suggested that low referral rates for PAC services are due to the few clinic hours that the health center is open; staff currently at the center are unable to provide the services; and desire to use private providers
4. The PAC program is seen as a "new" service to the community therefore the community needs to evaluate the services for themselves. It is anticipated that there will be an increase in client numbers overtime.

Pouk health center, Angkor Chum Operational District (Siem Reap Province)

There is one PAC-trained midwife at the Pouk health center who provides PAC services. Postabortion family planning is provided on-site immediately following uterine evacuation with pills, condoms, DMPA, IUD being available. Referrals are made to the RACHA clinic for Norplant and VSC. According to the provider, approximately 50% of clients accept FP methods immediately. However review of the client register indicated that the actual number of women accepting a method prior to discharge from the facility was closer to 25%. All of the women had chosen Depo-Provera as their contraceptive method. Fifty percent of women state that they desire another pregnancy or want like to see their menses before starting a FP method.

The midwife uses the RACHA recordkeeping form to track PAC treatment, counseling, methods, and referral activities. No return visits are scheduled regularly but women who do not accept family planning immediately post treatment are invited to return. During the course of the conversation, it became apparent that discussion of sexuality was a difficult topic for this provider to initiate with the women. There is a strong need for counseling to address when to initiate sex in relation to the return of fertility postabortion. The provider admitted that sexuality is not discussed due to the cultural awkwardness about raising or discussing this topic even when couples present for counseling before discharge.

VCCT is not available on-site but there are plans to include this service and build a facility for obstetric complications. Currently, most women in the catchment area of this health center deliver at the Swiss hospital, approximately 30 minutes away. When asked if midwives manage births by vacuum, the response was no since there is insufficient volume of deliveries to support this skill and there is no equipment.

When the provider was asked what additional training needs she had, she mentioned the need for refresher on infection prevention practices; use of MVA incomplete abortions from older gestations, and counseling. She was also asked if she felt comfortable to function as a trainer—she said yes.

In observing job aids available in the clinic, there were no Tiahart charts found in either of the two clinics. There were family planning methods charts and flipcharts available. Wall charts displaying the different stages of pregnancy charts were also available.

Assessment:
1. Family Planning methods are available at the time of emergency treatment.
2. The provider is uncomfortable with counseling re: sexual issues in regard to return to fertility.
3. There is no plan for follow-up of women who have not chosen a family planning method after emergency treatment.
4. There was no discussion on supervision of skills following PAC training

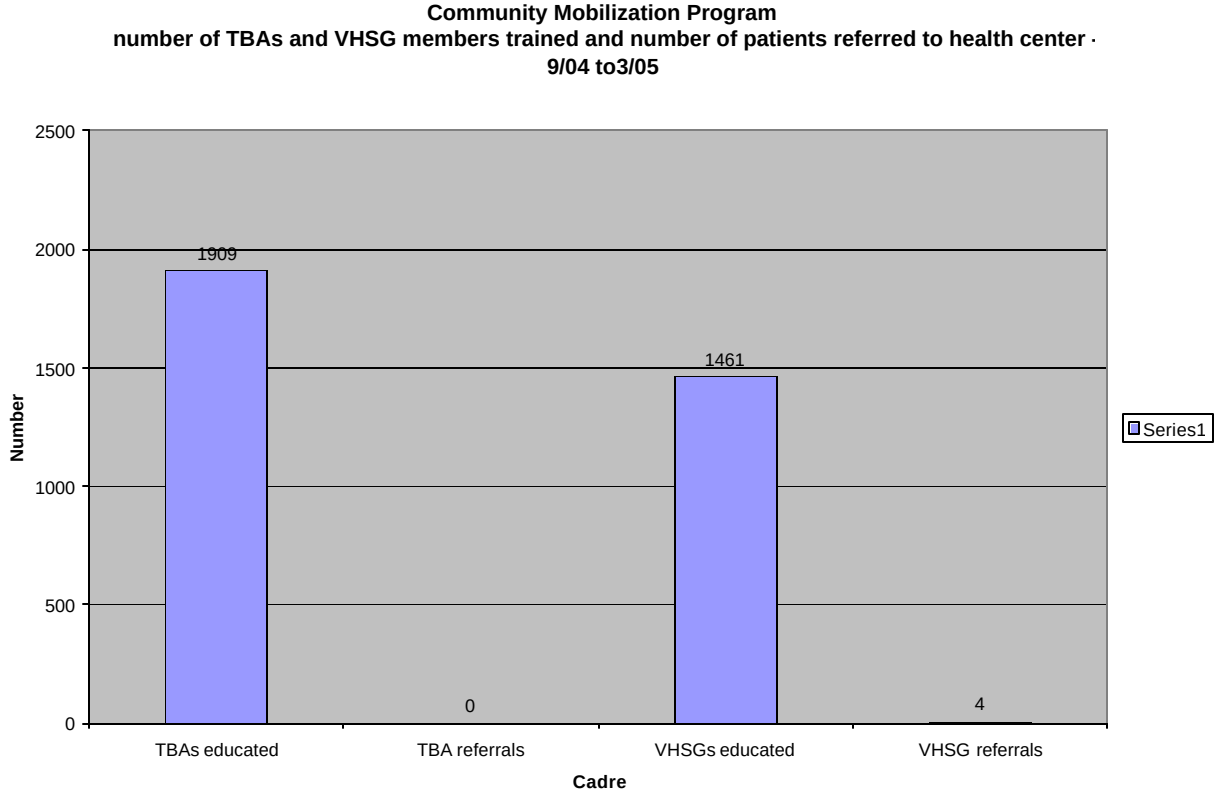
Areas of strength:
1. Good contraceptive method mix available for the clients
2. Family planning counseling and services are provided at time of emergency treatment
3. The site has enough client visits to be developed as a clinical training site.
4. There are plans for VCT services at this site.

Areas that need strengthening:
1. Further counseling/role-play is needed to aid the provider in her comfort for discussing sexual issues/return to fertility/family planning
2. There is the need for ongoing refresher training for infection prevention referral for family planning
3. Consider ways to provide FP methods that take into consideration the social context of needing to see menses before beginning FP method. (i.e. provide condoms as a routine at PAC visits; schedule patient for return visit for FP services or make referrals to VHSG or CBD for family planning methods; can provide pills even though woman has not started her menses)
4. While there is a good method mix of contraceptives available, all the women were on Depo-Provera. It will be important to ensure that the provider is comfortable with counseling and management of all the available methods.
5. A schedule for routine supervision of clinical skills needs to be established.
6. The Helms Amendment may need to be reviewed with staff. Also, the Tiahart chart needs to be placed in the clinics.

We visited another health center as well. At that site, the provider stated that there was a 66% STI rate among the PAC clients. FP counseling was provided following emergency treatment; however, she referred the clients to the FP clinic to receive their contraceptive method. Fifty (50%) of patients who did not accept a method after emergency treatment did return after their menses began. The provider stated that she did not feel "firm" in her MVA skills; she did not have a clinical practicum for her PAC training.

Siem Reap Village Health Education Sessions

As per the statistics received from RACHA, since September 2004, a total of 3370 community workers representing more than 3 times the projected number, have attended the one day awareness course regarding unsafe abortion risks and how to refer client in need of PAC services. While it was anticipated that 50% of the TBAs would refer clients immediately to health facilities, no referrals have been done by the TBAs.



Two village HE sessions were observed through translation. Approximately 50 women with their children were present for the sessions. The VHSGs were comfortable with the content and facilitated group participation very well. The second meeting had a very active TBA in attendance who had undergone the PAC orientation with the VHSG members. She encouraged the women to participate and ask their questions.

Women's questions related to side effects of contraceptive were dismissed as a "condition within your own body" rather than acknowledging the experiences as appropriate and what the options might be for handling them.

Though the second village session had a few men on the periphery of the meeting space, they were not included in the session. There is no evidence that involvement of men is an active part of these village meetings.

When each was asked what additional information they would like to received through these sessions, a suggestion from the first group was for more detailed information about family planning methods and a suggestion from the second group was information to help achieve pregnancy.

Assessment:

1. The community was receptive to the information and was able to identify danger signs related to unsafe abortion, availability of funds to cover transportation costs to the health facility.
2. Due to the hours that the sessions were held, there was no active involvement of men in the groups
3. While this activity has provided education to a large number of community members, it is still a top down approach to community mobilization. In this approach, the providers (RACHA) determine what messages it will provide to the community in regard to PAC.

Recommendations:
1. Racha should consider how to engage men and other family gatekeepers (i.e. mothers in law, etc) in the discussions. This may include providing group education at times when men are available.
2. Racha should identify ways to respond to additional topic areas that are being posed by the community.
3. Racha and USAID/Cambodia may wish to consider reviewing the PAC community mobilization program done in Bolivia to build upon the groups that currently exist in the community for further mobilization around PAC.

USAID/CAMBODIA

Persons Contacted: Mark A. White, Director, Charya Hen, Control Officer

The visiting team presented their work to date supporting the Mission's strategy for PAC scale-up, background information, and Cambodia's contribution to field-testing the Global PAC Resource Package with its accompanying User's Guide.

Discussions focused on

(a) Review of key findings from the PAC Resource Package's Research Compendium related to the three areas of the USAID PAC model;
(b) The use of RHAC sites for PAC services, e.g., emergency treatment that has no history of induced abortion services;
(c) RACHA's community partnership activities and provision of PAC training to MOH staff with strengthening of tracking postabortion family planning; and
(d) The potential for replicating the Bolivia Community PAC experience for maximizing access to care and use of family planning following treatment.

Since Cambodia has changed its abortion law, there is concern that USAID funded programs are in compliance with the Mexico City Policy and the Helms Amendment. Also, Mr. White was interested in how USAID/Cambodia could best support RACHA and other NGOs with TA and training activities for the MOH regarding the Helms Amendment and Mexico City Policy.

Review of Documents

ACQUIRE – Use of User's Guide of Global PAC Resource Package

Persons Contacted: Betty Farrell, Medical Associate; Jean Ahlborg, Medical Associate, Asia Region
Assessment:
1. The Global PAC Resource package has been useful for USAID/Cambodia and partners to take a comprehensive look at PAC program considerations. The User's Guide provides a systematic approach to assess what is needed to start PAC services and/or scale up existing services.
2. The overall organization of the three sections of the Resource Package makes "scanning the environment" manageable and easy

For example, existing local service delivery guidelines and training materials are in multiple documents and incomplete. The checklists and model resources within the Resource Package are useful in helping staff compare multiple documents and identify the gaps.

3. Once all the components of the Global Resource Package are available (as they currently are with the IEC/BCC materials), they will be useful in Cambodia, though modification for country adaptation will be necessary.
4. Much of the emerging research (such as that showing increased risk of adverse outcome with inter-pregnancy intervals of 5 months or less following abortion) will be useful in the development of policy, standards and protocols.
5. USAID's PAC strategy is very relevant to the health situation in Cambodia.
6. Recommended training resources (Kenya PAC training), for example, while comprehensive, are quite long (well over 500 pages), describing a 2 week training with little time allotted for clinical practice, an emerging priority for Cambodia's PAC program. This will prove a valuable resource, but may need to be considerably modified.

Strategic Framework for Equity Funds, 2003
A review of this document provides foundational language for the coverage of postabortion care under the Equity Funds. This will greatly assist women who may choose to not come to facilities for services due to lack of money. This document also reinforces the importance of the community in providing prevention education and funds for emergencies and family support.

1.2d - Aim and Objectives
"d. Initiate self-help actions within the community to provide support to poor families in seeking appropriate care especially for catastrophic illnesses and conditions." [16] **This language would support community mobilization activities that establish emergency funds for obstetric emergencies such as PAC.**

"g. "Encourage the use of preventive services (benefit to be defined) to avoid catastrophic events." [17] **This statement is useful to support paying for family planning methods. Use of modern contraceptive methods has proven to reduce unplanned pregnancy and repeat abortion.**

"…additionally, equity funds will operate by the following principles:
…d. The development of financing systems should go hand in hand with strategies for quality improvement/assurance and performance regulation of designated facilities and services."[18] **This statement would be helpful to support policies and service delivery guidelines that would reorganize family planning services so that they are provided at the same time and location as emergency treatment. Research data indicates a greater uptake of family planning when FP services are in the same location and offered at the same time as emergency treatment or FP services and methods are provided on the GYN ward prior to hospital discharge.**

"a) Financing of Priority Health Services: the benefit package should include, not necessarily confined to but as priority, the following services: i) Maternal and child health services including management of childhood infections, antenatal care and essential/emergency obstetric services."[19] **This language appears to support the use of the equity fund for postabortion care which is an obstetric emergency,**

"v. the facility is reimbursed at the end of the month for the number of cases that received adequate treatment and verified as poor, and not on a case by case basis."[20] **This statement illustrates the need for standardized clinical protocols for the treatment of PAC; ability for facilities to be reimbursed for evaluation/stabilization/proper and timely transfer of PAC patients. Also reinforces the need to use the local health facility as much as possible for PAC services.**

"b.3) A System for Quality Improvement and Assurance … there should be a process to ensure services at adequate quality and quantity. Equity Funds should be established in facilities where systems to achieve quality standards are activated with appropriate resources to support their delivery. In conjunction, there should be regular monitoring of consumer opinions and satisfaction. Some mechanisms should be in place to act as an advocate for the poor in case of problems, complaints and non access to care."[21] **This language provides the foundation for needing to ensure availability of commodities to provide PAC, supervision systems, quality improvement systems and service delivery guidelines to ensure quality PAC. This language also provides the need for active community dialogue between communities and health facilities**.

"b.4 …Other than these, equity funds may finance all other emergency and high cost hospital care to patients who are classified as "poor"."[22] **This language provides evidence that postabortion care would be covered by equity funds.**

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[16] Ministry of Health, Royal Government of Cambodia. Strategic Framework for Equity Funds: Promoting Access to Priority Health Services Among the Poor- Guiding Principles for Design, Management and Evaluation. Pg. 5
[17] Ibid, pg. 5.
[18] Ibid, pg. 5.
[19] Ibid, pg. 6
[20] Ibid, pg. 6.
[21] Ibid. pg. 7
[22] Ibid. pg. 11

"b.5) Community Involvement, Identification of Beneficiaries and Social Support to Families In Need.
Mobilizing community action is an essential ingredient of equity funds particularly in addressing the needs of poor families….Quite often pregnant women in remote villages are not able to travel to provincial or district hospitals because there is no one at home to take care of the children nor can they afford to leave the house unguarded. In such situations, the ultimate consequences from maternal deaths actually create costs higher than the loss of household belongings and jeopardize the lives and survival of the remaining children…"[23] **This language provides validation of coverage of postabortion care.**

"…Targeting equity funds in specific areas could experiment with community management of some funds for transportation of ill patients to health facilities and for mobilizing community/neighborhood actions to ensure care for the family while the patient is being hospitalized depending on the existence of social networks within the community…" [24] **This language is supportive of community financing schemes for patient transport and support of family needs during hospitalization.**

1.5 Significance in the Health Sector: Present and Future Context
"Currently, the MOH is in the process of securing funds … to set up equity funds in eleven districts where health services will be contracted out to NGOs."[25]
Assessment:
1. Equity Funds appear to support the following PAC interventions:
    a) emergency obstetrical care under which postabortion care should be considered;
    b) commodities to ensure that postabortion care can be provided;
    c) quality service delivery;
    d) community activities to promote education, establishment of community funding schemes for patient transport and family needs during an emergency.

Recommendation:
1. It is recommended that USAID/Cambodia work with the MOH to clarify language in this document to ensure that postabortion care services are covered and named in the document as a service to be provided under "emergency obstetrical care".
2. Postabortion care services should be established in the eleven districts where the equity fund operates to enable greater access to care due to the removal of the barrier of cost of services.
3. Recommend setting up PAC services within the eleven districts wherein the Equity Fund exits to increase access to PAC programs.

Postabortion Care Baseline Survey, June 2004
A community mobilization activity funded by CATALAYST was initiated in June, 2004. The objective of the project is to reduce maternal morbidity and mortality due to unsafe abortion. More specifically, the project will raise awareness about unsafe abortions and health risks by providing health information and education to villagers through existing information channels developed by RACHA in partnership with the MOH. The referral of women in need of PAC from villages to HCs will also improve. Finally after treatment, women will receive counseling about reproductive health care practices, especially about preventing unwanted pregnancy through appropriate family planning methods. Highlights of the findings are noted on the next page. Data from this survey is noted below in Figure 3. Assessment and recommendations based on these finding is noted below

Assessment
1. The knowledge level of the practicing midwives is no greater than that of the TBA or the women they are serving in regard to danger signs and risks related to incomplete abortion and miscarriage. In many aspects, the women in the community have a greater knowledge of danger signs and risks related to miscarriage and unsafe abortion than the midwives.

[23] Ibid, pg. 11.
[24] Ibid, pg 12.
[25] Ibid, pg. 12

Recommendation:
1. Education on danger signs and risks of unsafe abortion and miscarriage need to be provided to all TBAs and practicing midwives. A means of providing this information to these groups needs to be identified and provided as soon as possible.

2. All midwives completing any training in postabortion care needs to provide evidence of theoretical knowledge re: danger signs and risks related to abortion and miscarriage on their pre and post test examinations.

3. Questions that will measure knowledge of dangers signs and risks of abortions and miscarriage need to be integrated into a standardized curriculum and final examination.
Data from this baseline survey is noted below in Figure 3

✓ **Places where abortion; postabortion or incomplete abortion services are provided by midwives:**
13 midwives (46%) have performed abortion, postabortion or incomplete abortion services with curettage. Place where they provided services:

- 46% at home;
- 36% at health centers; --
  15% at referral hospitals

✓ **Complications experienced related to abortion:**
Of the 13 midwives who performed abortion, postabortion curettage or incomplete abortion services had complications, six midwives (46%) experienced complications when providing services

✓ **Demographics of the women (WRA; n-4224)**

- mean age = 33
- 96% married
- 38% experienced abortion or miscarriage

Of the women interviewed (n = 1740)

- 51% not using a birth spacing method

✓ **Referrals by women for problems with abortion**

- 30% refer to TBA
- 28% refer to private clinic
- 17% refer to health center
- 27% stay at home or self treat.
- 6% go to referral hospital

✓ **Knowledge of danger signs and risks related to miscarriage/unsafe abortion**

- 51% of WRA **did not know** of any signs or symptoms

Of the midwives included in the study (n=40);

- 60% **did not know** that bleeding was a danger sign;
- 66% **did not know** that fever was a danger sign
- 85% **did not know** that lower abdominal pain was a danger sign
- 73% **did not know** that bleeding was a risk of unsafe abortion/miscarriage
- 65% **did not know** that infection was a risk of unsafe abortion or miscarriage

- 84% **did not know** that uterine perforation was a risk of abortion or miscarriage
- 91% **did not know** that death was a risk of unsafe abortion or miscarriage

Of the TBAs included in the study (n=132)

- 57% **did not know** that bleeding was a danger sign
- 82% **did not know** that fever was a danger sign
- 83.5% **did not know** that lower abdominal pain was a danger sign
- 70% **did not know** that bleeding was a risk of unsafe abortion/miscarriage
- 82.5% **did not know** that infection was a risk of unsafe abortion/miscarriage
- 95% **did not know** that uterine perforation was a risk of unsafe abortion/miscarriage
- 74.9% **did not know** that death was a risk of unsafe abortion or miscarriage

Figure 3

Review of Clinical Statistical Data and Recommendations for Placement/Scale-up of Postabortion Care Services

Since the initiation of the postabortion care program in 2004, PAC services are now occurring at 11 sites in Cambodia in three operational districts; Siam Reap (Mondul 1; Bateay Srey; Preas dak; Chong Khmeas); Angkor Churm (Pourk, Sorsorsdom; Kokdong; Reul, Donkeo); and Kralanh (Prey Chrouk and the referral hospital). In reviewing the statistical data for these sites, projections for PAC caseloads have been made based upon the number of client visits during the first quarter of 2005. This exercise is critical to do for planning staff placement and establishing clinical training sites. All three ODs have sites in which there is a clear demand for PAC service. They also have sites where there has been little to no increase in PAC services. This information helps to determine patient demand for PAC services as well as indicate those areas in which further community mobilization is needed to create demand. (See Figure 4)

Operational District/Health Center	July to December, 2004	January to March, 2005	Anticipated Caseload January to July, 2005 (calculated based on numbers seen Jan-Mar, 2005)	Comparison of PAC visits from July, 2004 to December 2004 and January 2005 to July 2005	Number of villages served
Siam Reap OD	22	7	14	63%	
Mondul 1	11	4	8	82%	n/a
Banteay Srey	5	0	0	-100%	8
Preas dak	5	3	6	120%	n/a
Chong Khneas	1	0	0	-100%	3
Angkor Chum OD	40	14	28		
Pourk	12	7	14	116%	11
Sorsorsdom	9	4	8	88%	13
Kokdong	8	1	2	-75%	7
Reul	0	1	2	200%	14
Donkeo	1	1	2	100%	n/a
Kranlah OD	13	10	20		
Prey Chrouk	5	0	0	-100%	9
Referral Hospital	8	10	20	150%	

Figure 4

Health centers with a listing of "number of villages served" indicates where community mobilization activities are present as well as PAC services. In the first quarter of 2005, the following is noted. In Kralanh OD; the referral hospital has increased its PAC caseload by 125% without any community mobilization activities whereas there has been a 100% decline in PAC services provided at Prey Chrouk in which community mobilization activities occurred. It is possible that the community mobilization activities in Prey Chrouk influenced the increased PAC caseload seen at the referral Hospital.

In the Angkor Chum OD; even though there have been community mobilization activities in all surrounding communities except Donkeo, there has been little increase in PAC services except in the Pourk HC. There has been a decrease of 87.5% of PAC patients at Kokdong, no increase in patients at Donkeo, and only one patient seen in 9 months at Reul.

Data for the Siam Reap OD indicates by July, 2005, a total of 14 patients will have received PAC services compared to 22 in the first six months of the program representing a 39% decrease in the patient caseload. Mondul has seen the most number of patients without the advantage of community awareness activities. There has been a decrease in patient number in both areas (Banteay Srey and Chong Khneas) where community awareness activities were provided.

Assessment:

1. There does not seem to be a correlation between the number of PAC clients served at health centers and the community awareness activities in the surrounding communities.
2. There was no data to validate the choice of health centers for the placement of postabortion care services. It is possible that demographic data on unplanned pregnancy, maternal mortality, CPR; and incomplete abortion in these areas may not support the need to place postabortion care services in some of these health centers. Also, the decrease in PAC services in many health centers after the PAC program was initiated may be reflective of the decreased need for postabortion care services in these communities.

3. The lack of enough patient numbers for PAC services will limit the ability of the provider to remain competent in clinical skills for emergency treatment.

Recommendations:
1. Strategic placement of postabortion care services in ODs should be based upon demographic data on unplanned pregnancy, incomplete abortion; obstetric emergencies presenting at health facilities; CPR. It may be more appropriate to provide the complete package of postabortion care services at selected health centers that can serve more a number of villages in close proximity. Other facilities could evaluate, stabilize and refer patients to those sites doing complete postabortion care. All facilities should be able to provide postabortion family planning.
2. Clinical training sites could be established in each OD at the following sites: Siam Reap OD – Modul 1; the Referral Hospital in Kranlah OD; and Pouk at Angkor Chum OD.
3. Consolidation of postabortion care activities in sites that are doing less than 2 cases per month should be considered. Also increased access to PAC could be accomplished by increasing health facility hours from 4 hours a day to 8 hours/day at selected facilities. .
4. Increased community mobilization activities may increase the demand for PAC services.

Other:
As per the 2005 Joint Planning Review of the Department of Planning and Health Information, MOH; the four month training course for midwifery training has not taken off due to the lack of budgetary support. Only 62% of the targeted number of health center staff with MPA 8 training was trained in 2004. HRD needs technical assistance in planned work on accreditation of training courses to ensure quality.

Use of modern contraceptive methods for birth spacing and limiting remained at 20% below the target of 25%. This is despite a large unmet need for contraception (33%) as documented during the CDHS 2000. The percent of essential drugs at health centers that faced stock outs reduced significantly to 5.7% against the target of 7.2%, connotating a market improvement in drug logistics and management.
Strategies need to be developed to increase the coverage of and access to: reproductive health services such as birth spacing; safe delivery; emergency obstetric care; iron supplementation; and postpartum care (suggest the inclusion of postabortion care). Priorities for 205-2006 – national policies on health care need to be compiled.

Conclusions and Recommendations to USAID/Cambodia

Conclusions and recommendations will be made in response to the questions posed in the scope of work, with additional findings noted as other"

1. Does the proposed USAID/Cambodia strategy (PAC activities) accurately respond to the Global PAC Initiative and compliance with the Mexico City Policy?
Review of the USAID/Cambodia PAC strategy showed that it was very inclusive of demographic data in Cambodia to justify the need for a postabortion care program. In October 2004, the final USAID PAC Strategy was completed which contains the USAID PAC model, a results framework, and indicators for the Global Health Bureau and country programs. Small revisions to the USAID/Cambodia PAC strategy need to be made to include the components of STI evaluation and treatment; HIV counseling and/or referral for testing; demographic information on STIs in Cambodia; and the USAID results framework and indicators suitable for the Cambodia PAC program. These changes were included in the draft USAID/Cambodia PAC strategy that was submitted to Dr. Charya Hen. This is included in the appendix of this document. Further information regarding how USAID plans to monitor compliance with its PAC program implementers can be included in the strategy. However it is recommended that this be completed after the planned visit of Barbara Seligman and Laura Marks in June, 2005.

2. What are the current activities that should be continued and those, which should be discontinued? Please provide the rational for these recommendations.

Findings of the PAC program in Cambodia indicate that the PAC program includes training of providers and community mobilization activities through RACHA, service delivery through RHAC, and program monitoring through CARE. More than 100 PAC providers have been trained since 2003 and greater than 3000 TBAs, Village Health Support Groups and community residents have received education on danger signs and risks/complications related to unsafe abortion. Via a small grant provided to RACHA by CATALYST, reimbursement for the cost of transportation fees for referral is being provided. Each area is addressed as follows:

PAC Training:

While PAC training has occurred, the training is not complete. Directors and staff of all sites visited value PAC training for service delivery and request that more providers be trained. However, they request that clinical experience be part of the training and request post training follow-up/supervision to reassure that they are "doing the right thing". This results in use of additional resources that may not be needed. Postabortion care training does not provide clinical practice experience for building competence and confidence in managing uterine evacuation techniques and for developing clinical judgment. Lack of security in their clinical MVA skills is evidenced by the use of curettage after MVA to ensure that the uterus has been completely evacuated. While the schedule provides for a time of pre and post testing; there are no tools to indicate that the learner has demonstrated proficiency in theoretical or clinical knowledge attainment.

Recommendation.

PAC Training:

a. USAID should postpone the training of additional PAC providers until the current PAC program is strengthened in the following manner:

i. Establishment of a national PAC policy separate from the Declaration of Abortion.

ii. Establishment of a national standardized PAC curriculum that includes an examination to test theoretical and clinical skill proficiency. The minimum standard for proficiency should be 85% for both theoretical knowledge and counseling, and clinical skills competency.

iii. All providers who have been trained should be tested with the use of a written examination to determine their theoretical knowledge attainment and clinical skills competency. The minimum standard of 85% should be established for passing the theoretical examination. They should also be tested on their clinical skills via demonstration on the model with correct completion of 100% of the steps needed to complete MVA for emergency treatment. This action should occur for all providers trained by RACHA since October 2004.

iv. Establishment of a supervisory system for postabortion care services.

v. Build up the patient caseload at the Mondul 1; Pourk, and the Referral Hospital in by strategically closing down PAC services in their OD where there is 2 or less PAC visits/month

vi. Work with the MOH in reorganizing responsibilities of midwives who are doing PAC services to not have to do community teaching. These tasks could be done by primary midwives, thus freeing up secondary midwives which could result in longer clinic hours and increased availability to PAC services. Perhaps there could be increased hours at the health center remaining open by detailing staff from facilities wherein PAC services are ended to those facilities where PAC services are being built up.

b. USAID/Cambodia can assist clinical training by seeking clinical training opportunities in other countries for the master trainers. This may be necessary for training other providers as well until Cambodia sites can build up their caseload to support clinical training. Currently, the patient caseload at most health facilities is not enough to support clinical training of providers.

Candidates for training in other countries should demonstrate their theoretical competency by passing a written examination with 85% before being considered a candidate for clinical training.

c. As per Dr. Kanal, safe abortion services are only included in the comprehensive package of activities. These services would probably be more available in secondary or tertiary facilities, allowing PAC services to be done as a part of the minimum package of activities at health centers. USAID can assist the MOH in strategically placing its PAC programs in areas where PAC services are truly needed by ensuring that a needs assessment for PAC services has been completed before initiating services. This will decrease the number of facilities wherein PAC services are underutilized and decrease the number of providers who complete training but are unable to maintain clinical skills due to a low patient caseload.

PAC Service Delivery

There does not seem to be a needs assessment done to determine where postabortion care services will be placed within Cambodia. Rather there seems to be a schedule to introduce postabortion care services in every health center. While it is necessary to provide triage, evaluation, and stabilization of patients presenting with an obstetrical emergency, it is not necessary for every health center to do PAC emergency treatment for uterine evacuation. It is possible to stabilize and refer the patient to another facility of uterine evacuation as long as it is safe for the patient. However, postabortion family planning services should be available at every health center.

Reorganization of health services to allow postabortion family planning to occur at the same location and same time as PAC emergency treatment is inconsistent. In most settings, barriers to postabortion birth spacing services are numerous: services are not provided in the same space as emergency treatment and recovery (this is consistently true at the health center level, though less consistent in the OD health centers associated OD hospitals); women generally

must pay another fee for FP services postabortion. There is the lack of a tracking system to ensure that women actually received the services for which they were referred for.

The orientation of community-based personnel (TBA, VHSG) should include basic information about contraceptive side effects and encourage referral for management. Selected minor side effects management could be included during their orientation to support women just starting a method. Referrals to health centers would mean that the personnel there would need to know how to appropriately manage contraceptive side effects to make the woman's visits worth the time, expense, and support quality services.

Recommended Changes

1. Prior to initiating postabortion care emergency treatment services at any health facility; a needs assessment needs to be completed to ensure that this service is needed in that locale. All health facilities however should have the capability of providing triage, evaluation, stabilization and referral for complications and postabortion family planning services

2. An examination to test the theoretical knowledge of contraceptives, mechanism of action and management of side effects is needed for all PAC providers. The minimum standard for passing the examination should be set at 85%.

3. Reorganization of services; whole site training, facilitative supervision, and use of COPE is needed to reorganize family planning to ensure access to counseling and methods at the time of PAC emergency treatment.

Community Mobilization:

1. Community awareness and mobilization activities are doing an effective job of informing women community members of the complications of abortion, the need for prompt care, the availability and safety of using birth spacing methods following an abortion. It is less clear, that this information has led to increased identification and utilization of PAC trained health providers in local health centers (number of PAC clients seen is steadily increasing, as is the percentage of women given or starting a method prior to discharge). However this increase in patient caseload is not uniformly seen for health facilities whose surrounding communities received PAC community awareness messages.

2. Support for referral/transport seems underutilized in our limited sampling of sites and providers, with numerous community and health center factors beyond the control of the project probably impacting utilization of this service (erratic availability of midwives at the health centers, and TBAS or VHSG members who can provide voucher for transportation fees; concerns about confidentiality, preference for going to the hospital rather than the local health center, etc).

3. Community awareness and mobilization activities do not seem to involve focused attention towards men and their role in responsible behaviors for optimal SRH.

4. Community mobilizers' Birth Spacing messages, especially with regard to managing side effects, could probably be improved with a refresher training on this topic.

Recommendations for Change:

1. Investigate ways to increase the types of communities that receive these messages. There are many communities that are established in Cambodia; i.e. Factory workers, sex workers, wat grannies; Buddhist monks; men, etc. See how the PAC messages and family planning messages can be provided to them as well. This may require change in hours, change in persons providing messages, etc.

2. Additional education to TBAs and VHCGs on usual side effects of contraceptives would be helpful.

3. Suggest that the reimbursement of the transportation fee not be dependent upon a referral by a TBA or VHSG member. As per our discussions, sometimes these individuals may not be available in the community when someone needs to be going to a health facility. This may present a barrier to early PAC services. The recommendation would be to assess another way in which individuals can be reimbursed rather than initially seeing the TBA or VHSG member.

3. Evaluate the PAC community mobilization program that was completed in Bolivia and will soon be replicated in Kenya. This community empowerment approach engages all types of individuals in the community; requires for a mapping of services and providers in the community; and engages the everyday community resident to be a facilitator of

their community group and catalyst for change. Outcomes of the PAC activity in Bolivia due to community involvement have been increased hours at health facilities and pharmacies; change in elected members to the local health committees; regularly scheduled meetings with the health facility and community members; additional health topics identified and addressed by health personnel.

Other
1. Suggest working with the MOH to having language for the Equity Fund that ensures that postabortion care services are recognized as obstetrical emergency services for coverage under the Equity Fund. This will remove barriers to care for women needing postabortion care.

3**. Is what USAID/C proposing for PAC in line with the current national safe motherhood and PAC policy?**
Review of the Safe Motherhood Policy and Strategy indicates that all the components of the USAID PAC model are included in the Safe Motherhood Policy and Strategy. Please see the appendix B for a comparison of the USAID PAC model and Safe Motherhood Policy and Strategy.

4. **What are the existing M & E tools for PAC program monitoring and evaluation? Dose USAID/C adequately address M & E? (spotlight central level to community level**) The only tools that were seen for M&E in RACHA, RHAC and governmental health centers was a data gathering tool that had been created by RACHA. This tool does not capture much information that would allow these facilities to respond to the indicators and intermediate results of the USAID PAC Results Framework. During this visit a user-friendly data collection form was created by Carolyn Curtis, USAID/Washington that would allow data collection that would comply with the USAID PAC Results framework. Also, Indicators and Intermediate Results that would coincide with the Cambodia PAC program were identified with Dr. Charya Hen and are in Appendix C.

5**. From initial assessment, is the OPH and partners working within the parameters of Mexico City Policy—as MCP relates to PAC?**
Review of the activities of RHAC and RACHA showed compliance with the Mexico City Policy. While staff stated that there was no abortion related activities occurring at RHAC or RACHA, the staff had many questions regarding Mexico City Policy. There was no review of documents that indicated ongoing continuing education for staff re: this issue; documentation of attendance of staff at these meetings; policies to deal with noncompliance of Mexico City Policy. The training curriculum for Postabortion care did not include information on the Helms Amendment and the Mexico City Policy and how this relates to daily clinical practice. Please see appendix A for the review of each organization. CARE will need to be further evaluated by the USAID/Washington team of Barbara Seligman and Laura Marks during their visit in June, 2005.
Areas that need further evaluation for all organizations are the technical assistance that they provide the government in policy making. All organizations will need to establish policies re: how they will ensure that staff are educated on Mexico City Policy and the Helms Amendment; how often refresher training will be held, and how they will document that staff have received this information. Also each organization will need to establish policies and a disclaimer statement to ensure that employees do not improperly represent the agency in regard to activities they conduct as individual providers. USAID/Cambodia will also need to establish guidelines for how they plan to monitor activities of their partner organizations. It would be recommended to

Recommendations:
a. Have the analysis of each organization that is included in Appendix B be reviewed by the USAID/Washington team in June 2005.
b. Suggest that USAID/Cambodia review the USAID Office of Inspector General Audit of USAID/Bangladesh's Nongovernmental Organization (NGO) Service Delivery Program, Audit Report No. 5-388-05-004-P, March 21, 2005 and Appendices A-H prior to the USAID/Washington visit in June to glean what can be applied to USAID/Cambodia for monitoring of programs.

c. Use of the tool in Appendix C may assist USAID/Cambodia in performing an initial analysis for compliance with Mexico City Policy/Helms Amendment

References

Birth Spacing Policy for Cambodia

Bringing PAC to Where the Real Needs are in Cambodia, RACHA proposal submitted to CATALYST, April 21, 2004.

CARE – USAID Narrative Workplan Fiscal year 2005

Chutema, P. RHAC PAC Services, Presentation to USAID, April 27, 2005

Ministry of Health Royal Government of Cambodia - Strategic Framework for Equity Funds: Promoting Access to Priority Health Services Among the Poor; Guiding Principles for Design, Management and Evaluation, Version 1, September 2003

Ministry of Health 2005 Joint Annual Performance Review, March 1-3, 2005. Intercontinental Hotel, Phnom Penh, Cambodia.

Monthly PAC Service Report of PAC Trained Midwives

National Policy Prevention of Mother to Child Transmission of HIV

Postabortion Care Training Lesson Plan

RACHA Activities Matrix at Siem Reap Province 2004 Siam Reap OD, Angkor Chum OD (update February 2005)

RACHA/EngenderHealth - Postabortion Care

RACHA Postabortion Care Baseline Survey, June 2004

RACHA Workplan, April 01, 2004 to September 30, 2005

Reproductive Health Association of Cambodia USAID Partner Strategic Workplan, 1st October 2004 to 30th September 2005

RHAC Clinical Protocols, Version January 2003

Schedule of Postabortion Care Training

USAID/Cambodia, Post Abortion Care in Cambodia: The strategy. Strategic Objective 9: Increased use of high impact HIV/AIDS and Family health services and appropriate health seeking behaviors.

USAID Office of Inspector General Audit of USAID/Bangladesh's Nongovernmental Organization (NGO) Service Delivery Program, Audit Report No. 5-388-05-004-P, March 31, 2005.

USAID Postabortion Care Strategy, October 2004.

Appendix A - Summary of Observations/Assessments/ Recommendations by Organization

MOH National Maternal and Child Center

Assessment:

1. Dr. Rathavy is interested in establishing national policy, curriculum and service delivery guidelines for postabortion care.
2. There is great interest in using the Global PAC Resource Package for completing the above named items. Dr. Rathavy requested that she be provided with the materials for use.
3. Dr. Rathavy Is interested in meeting with Barbara Seligman in discussing the Helms Amendment and Mexico City Policy for the scale up of PAC programs in Cambodia

CARE

Assessment:
Mexico City Policy/Helms Amendment Issues:
1. The MAARD from USAID/Cambodia was provided to CARE International, a US based NGO. However, the staff in Cambodia is on contract with CARE/Australia and CARE/Cambodia. The funding stream from CARE International to CARE/Cambodia and CARE/Australia is not clear.
3. Due to a recent contract that CARE/Cambodia has entered into with the MOH, it is unclear as to whether their activities will violate any portion of the Mexico City Policy or Helms Amendment.

Postabortion Care:
Care has:
1. Expertise in VCCT/PMTCT and STI training
2. Ready networks for introducing IEC/BCC information regarding postabortion care; i.e. Monks, youth, factory workers; community resilience programs; casino workers, etc. This provides new audiences for introducing information on postabortion care; need for family planning, and complications related to miscarriage and unsafe abortion.
3 Expertise in doing facilitative supervision and use of COPE for quality improvement.
4. Expertise in working at the national policy level to effect change.

Recommendation for implementation of postabortion care
Mexico City Policy/Helms Amendment Issues – Recommendations were made to CARE as follows:
1. Obtain documentation that shows the relationship between CARE International and CARE/Cambodia. This will provide clarity re: funding for CARE/Cambodia staff and their level of accountability to the Mexico City Policy.
2. Provide copy of the contractual arrangement with CARE and MOH for this most recent contract to determine their management role and to identify any areas that may present opportunity for violations of the Mexico City Policy
3. Document further questions so that they can be addressed by Barbara Seligman during her visit in June, 2005.

Postabortion Care Programmatic Interventions
CARE can assist in the scale-up of postabortion care programs in the following ways:
PAC Component One - Emergency treatment for women experiencing postabortion care
1. Participate in the development of national policy on postabortion care separately from the comprehensive abortion care policy.
2. Participate in the development to a national curriculum for postabortion care
3. Participate in the development of national service delivery guidelines for postabortion care
4. Begin to prepare sites for doing postabortion care where comprehensive abortion services will be provided by preparing a different space for postabortion care that will be physically separated from planned abortion services in all government health facilities managed by CARE.
4.
5. Assist in developing selected sites for clinical training sites for postabortion care training
6. Participate in policy development that will ensure availability of pain medication for emergency treatment
7. Assist the MOH in integrating indicators for postabortion care in its MIS system

PAC Component Two – FP counseling and service delivery; STI Evaluation and treatment; HIV counseling and/or referral for testing
1. Assist the health centers in reorganizing FP services (i.e. rearranging services so that FP counseling and service provision are in the same location as PAC emergency treatment services regardless of MVA or D&C).
2. Work to ensure drug, equipment, FP commodities for PAC programs.
3. Position VCCT sites or VCCT at postabortion care sites for easy referral of PAC clients to HIV testing.

4. Assist in repositioning services for STI evaluation and treatment so that they are provided at the same time of emergency treatment.
5. Strengthen the supervision of PAC services through facilitative supervision. It will be important to have different personnel supervising PAC services than those who provide supervision for comprehensive abortion services.
6. Identify problems and increase the quality of services by using COPE for quality improvement.
7. Work with CBD workers to be partnered with TBAs and midwives to enable the delivery of family planning commodities in communities and villages

PAC Component Three – Community Empowerment via community awareness and mobilization
1. Integrate messages regarding unsafe abortion; prevention of unplanned pregnancy/abortion by use of family planning; emergency transport and establishment of emergency funds for obstetric emergencies in activities in the many community networks that CARE has established. Audiences for these messages would include garment factory workers; monks; WAT grannies; community resilience activities;
2. Educate peer educators on postabortion care to reach all the populations i.e. Couple in the Know program; sex workers; uniformed service; peer educators.
3. Evaluate the usefulness of the PAC community mobilization activity that was carried out in Bolivia for its applicability to CARE's BCC programs.

RHAC

Assessment:
1. RHAC appears to be well organized with a variety of services that are appropriate for integration into postabortion care services.
2. The staff is aware of Mexico City Policy and desires to be in compliance with it.
3. The statistical data re: PAC cases received indicate that many women seen for postabortion care services are possibly self-aborting by use of medications obtained from the pharmacy to induce bleeding, thus prompting their need for postabortion care services.
4. The staff is concerned about the safety and correctness of their clinical skills

Areas of Strength:
1. PP2 site has the capability of being a training site for PAC clinical training due to the numbers of patients seen during the first 4 months of 2005.
2. STI/HIV services are readily available in the site
3. The staff has the desire to provide quality PAC services due to their request to have clinical supervision of their skills
4. The staff had the desire to do evidence based programming via interpretation/assessment of their clinical data
5. There is a referral mechanism in place for receiving clients from outside referrals as well as referring clients to higher levels of care.
6. There is a 2nd visit for PAC services which can allow for evaluation after emergency treatment and increased uptake of family planning methods
7. There is a network in place through which PAC community mobilization activities can be implemented.
8. The presence of clinical protocols for patient management.

Areas to be strengthened:
1. While 100% of patients receive family planning counseling, only 9% are leaving the facility with a family planning method. There is the need to investigate with staff and with patients how family planning counseling and service delivery can be improved.
2. The lack of clinical training for emergency treatment is problematic for the program. The quality of the clinical services cannot be ascertained due to lack of testing of clinical skills and ongoing clinical supervision
3. There is need for a standardized curriculum which will allow for testing of both theoretical and clinical knowledge and skills. This would also include counseling skills.
4. RHAC Clinical protocols need to include management of complications related to miscarriage and incomplete abortion.

Recommendations:

1. Establish PP2 as a clinical training site for RHAC PAC providers. This will include identifying staff that will become the master trainers for PAC. These individuals may need to go outside of Cambodia to obtain the necessary clinical experience needed to refine their present MVA clinical skills.
2. A standardized PAC curriculum for Cambodia should be established that will provide for theoretical and clinical testing of all potential PAC providers. The recommended passing score for the theoretical and clinical skills should be a minimum of 85%.
3. To ensure quality PAC services as well as provide reassurance to current PAC providers, all providers who have been trained should be tested on their theoretical and clinical knowledge and skills for PAC. The minimum passing scores should be 85%. Providers who are able to score 85% on the theoretical knowledge can then go on to be tested in clinical skills. Providers who are not able to obtain this score could be tested again; those not passing should no longer be able to provide services in the areas in which they did not receive a passing score of 85%.
4. Before initiating PAC services in any further sites, need to strengthen the quality of PAC services and build up patient caseloads in the sites where PAC is currently being provided. Establishment of a quality clinical service delivery site is needed before providing clinical training to additional providers. While emergency treatment services may not be provided in new sites, these sites can be prepared for PAC services by beginning the process of reorganizing family planning counseling and service delivery to occur at the same time and location as planned emergency treatment. Community mobilization messages regarding complications due to postabortion care and the need for family planning can be initiated in these areas.
5. Standardized clinical service delivery guidelines and standard protocols need to be established at all PAC sites.

RACHA

The Red Cross Hospital

Assessment:

1. The Red Cross Hospital has a busy obstetrical service however while there are 150 births per month, there are only 50 to 60 total family planning visits per month representing 33% to 40% of postpartum women coming for a family planning visit.
2. The midwifery staff report that STI treatment needs are great (90%) among PAC patients.
3. The Red Cross Hospital serves an important role as one of two training sites for nurses and midwives
4. The midwives are uncertain about their MVA skills as they use curettage after MVA treatment to ensure uterine evacuation.

Areas of strength:

The Red Cross Hospital:

1. Has a busy antenatal service
2. Has the infrastructure in place for PMTCT and STI evaluation
3. Has a Good method mix of contraceptives available in the hospital setting
4. Provides pain medication as needed to clients for emergency treatment

Areas needing strengthening:

1. There are only 5 to 6 new FP cases per month; this represents approximately 3% of the number of women who deliver
2. There is no tracking system in place to monitor referrals to the FP clinic that occur after FP counseling.
3. There is a lack of clinical training for MVA skills. Due to this, there appears to be lack of confidence in MVA skills as curettage is used to ensure complete uterine evacuation. This results in use of two technologies to complete uterine evacuation which is an additional expense to the hospital
4. It is uncertain if there has been whole site training regarding PAC. This would include orientation to supervisors and hospital administration on postabortion care and the need to reorganize location of services to ensure ability for clients to receive fp method in same place as emergency treatment
5. There are no clinical checklists seen with the RACHA curriculum that would identify necessary steps in providing postabortion care services or demonstrate competency in skills attainment
6. There is no evidence of pre and post test examination to evaluate the theoretical knowledge of the trainee.

Recommendations:
1. It is recommended that ACQUIRE determines whether orientation of all hospital administration/supervisors to PAC services has occurred. This will allow for better understanding of the PAC program and support for services/commodities needed for PAC.
2. Whole site training may be needed for postabortion care.
3. ACQUIRE will need to assist RACHA in helping the MOH to reorganizing services so that family planning counseling and service delivery can occur in the same place and at the same time that PAC emergency treatment occurs. FP methods will need to be relocated to the location of PAC emergency treatment.
4. RACHA should consider training all GYN and OB ward staff in family planning counseling. This will allow a family planning counselor to always be available for the PAC and postpartum patients.
5. ACQUIRE needs to assist RACHA in developing an ongoing supervision system so that transfer of learned of quality PAC skills to the workplace is ensured.
6. ACQUIRE needs to assist RACHA in updating the curriculum so that clinical skills checklists for all skills necessary to carry out PAC services; i.e. counseling skills, MVA skills; FP provision. These items are included.
7. ACQUIRE needs to assist RACHA in developing pre and post test examination in postabortion care is needed to measure theoretical knowledge base for PAC if this is not already included in the curriculum.

USAID Global PAC Resource Package

Assessment:
1. The Global PAC Resource package has been useful for USAID/Cambodia and partners to take a comprehensive look at PAC program considerations. The User's Guide provides a systematic approach to assess what is needed to start PAC services and/or scale up existing services.

2. Overall organization of the three sections of the Resource Package makes "scanning the environment" manageable and easy

   For example, existing local service delivery guidelines and training materials are in multiple documents and are incomplete. The checklists and model resources with the Resource Package has been useful in helping staff compare these multiple documents and identify gaps that exist.

3. Both the comprehensive, systematic approach and the recommended resources, once available (as they currently are with the IEC/BCC materials) will be useful in Cambodia, though modification will be necessary.

4. Much of the emerging research (such as that showing increased risk of adverse outcome with inter-pregnancy intervals of 5 months or less following abortion) will be useful in the development of policy, standards and protocols.

5. USAID's PAC strategy is very relevant to the health situation in Cambodia.

6. IEC/BCC materials have already been reviewed and preliminary Cambodian versions developed by RACHA and RHAC for use within their programs.

7. Recommended training resources (Kenya PAC training), for example, while comprehensive, are quite long (well over 500 pages), describing a 2 week training with little time allotted for clinical practice, an emerging priority for Cambodia's PAC program. This will prove a valuable resource, but may need to be considerably modified.

8. The Global PAC Resource package does not have materials for mass media. This is a gap in the materials presented.

Areas that need strengthening:
1. USAID needs to identify resources on PAC for use in the mass media.

Siem Reap Provincial Health Directorate

Assessment:
1. Safe abortion services have not been initiated due to the lack of standard guidelines for implementation of this service

2. While family planning is provided as a part of PAC services, cultural influences affect women's decision to accept a method of birth spacing
3. The PAC community awareness program is seen favorably in its role of increasing referrals to health facilities for PAC services
4. The role of the community is valued in its role of promoting change in quality of services
5. Staffing levels affect the ability to provide all types of services.
6. TBAs have a major role in the performance of deliveries and other services.

Siem Reap Provincial Operational District (Mondul Muy Health Center)

Assessment:
1. There was an anticipation of higher client numbers at the health facilities after the community was provided with education on danger signs and complications related to miscarriage and unsafe abortion.
2. It is expected that TBAs and VHCGs would provide referrals and education during their free time.
3. It is suggested that low referral rates for PAC services are due to the few clinic hours that the health center is open; staff currently at the center are unable to provide the services; and desire to use private providers.
4. The PAC program is seen as a "new" service to the community therefore the community needs to evaluate the services for themselves. It is anticipated that there will be an increase in client numbers overtime.

Pouk health center, Angkor Chum Operational District (Siem Reap Province)

Assessment:
Family Planning methods are available at the time of emergency treatment.
2. The provider is uncomfortable with counseling re: sexual issues in regard to return to fertility.
3. There is no plan for follow-up of women who have not chosen a family planning method after emergency treatment.
4. There was no discussion on supervision of skills following PAC training

Areas of strength:
1. Good contraceptive method mix available for the clients
2. Family planning counseling and services are provided at time of emergency treatment
3. The site has enough client visits to be developed as a clinical training site.
4. There are plans for VCT services at this site.

Areas that need strengthening:
1. Further counseling/role-play is needed to aid the provider in her comfort for discussing sexual issues/return to fertility/family planning
2. There is the need for ongoing refresher training for infection prevention referral for family planning
3. Consider ways to provide FP methods that take into consideration the social context of needing to see menses before beginning FP method. (i.e. provide condoms as a routine at PAC visits; schedule patient for return visit for FP services or make referrals to VHSG or CBD for family planning methods; can provide pills even though woman has not started her menses)
4. While there is a good method mix of contraceptives available, all the women were on Depo-Provera. It will be important to ensure that the provider is comfortable with counseling and management of all the available methods.
5. A schedule for routine supervision of clinical skills needs to be established.
6. The Helms Amendment may need to be reviewed with staff. Also, the Tiahart chart needs to be placed in the clinics.

Another health center was also visited. At that site, the provider stated that there was a 66% STI rate among the PAC clients. FP counseling was provided following emergency treatment; however, she referred the clients to the FP clinic to receive their contraceptive method. Fifty (50%) of patients who did not accept a method after emergency treatment did return after their menses began. The provider stated that she did not feel "firm" in her MVA skills; she did not have a clinical practicum for her PAC training.

Siem Reap Village Health Education Sessions

Assessment:

1. The community was receptive to the information and was able to identify danger signs related to unsafe abortion, availability of funds to cover transportation costs to the health facility.
2. Due to the hours that the sessions were held, there was no active involvement of men in the groups
3. While this activity has provided education to a large number of community members, it is still a top down approach to community mobilization. In this approach, the providers (RACHA) determine what messages it will provide to the community in regard to PAC.

Recommendations:
1. Racha should consider how to engage men and other family gatekeepers (i.e. mothers in law, etc) in the discussions. This may include providing group education at times when men are available.
2. Racha should identify ways to respond to additional topic areas that are being posed by the community.
3. Racha and USAID/Cambodia may wish to consider reviewing the PAC community mobilization program done in Bolivia to build upon the groups that currently exist in the community for further mobilization around PAC.

Strategic Framework for Equity Funds, 2003
Assessment:
Equity Funds appear to support the following PAC interventions:
a) emergency obstetrical care under which postabortion care should be considered;
b) commodities to ensure that postabortion care can be provided;
c) quality service delivery;
d) community activities to promote education, establishment of community funding schemes for patient transport and family needs during an emergency.

Recommendation:
1. It is recommended that USAID/Cambodia work with the MOH to clarify language in this document to ensure that postabortion care services are covered and named in the document as a service to be provided under "emergency obstetrical care".
2. Postabortion care services should be established in the eleven districts where the equity fund operates to enable greater access to care due to the removal of the barrier of cost of services.
3. Recommend setting up PAC services within the eleven districts wherein the Equity Fund exits to increase access to PAC programs.

Postabortion Care Baseline Survey, June 2004
Assessment
1. The knowledge level of the practicing midwives is no greater than that of the TBA or the women they are serving in regard to danger signs and risks related to incomplete abortion and miscarriage. In many aspects, the women in the community have a greater knowledge of danger signs and risks related to miscarriage and unsafe abortion than the midwives.

Recommendation:
1. Education on danger signs and risks of unsafe abortion and miscarriage need to be provided to all TBAs and practicing midwives. A means of providing this information to these groups needs to be identified and provided as soon as possible.

2. All midwives completing any training in postabortion care needs to provide evidence of theoretical knowledge re: danger signs and risks related to abortion and miscarriage on their pre and post test examinations.

3. Questions that will measure knowledge of dangers signs and risks of abortions and miscarriage need to be integrated into a standardized curriculum and final examination.
Data from this baseline survey is noted below in Figure 3

Review of Clinical Statistical Data and Recommendations for Placement/Scale-up of Postabortion Care Services
Assessment:

1. There does not seem to be a correlation between the number of PAC clients served at health centers and the community awareness activities in the surrounding communities.
2. There was no data to validate the choice of health centers for the placement of postabortion care services. It is possible that demographic data on unplanned pregnancy, maternal mortality, CPR; and incomplete abortion in these areas may not support the need to place postabortion care services in some of these health centers. Also, the decrease in PAC services in many health centers after the PAC program was initiated may be reflective of the decreased need for postabortion care services in these communities.
3. The lack of enough patient numbers for PAC services will limit the ability of the provider to remain competent in clinical skills for emergency treatment.

Recommendations:
1. Strategic placement of postabortion care services in ODs should be based upon demographic data on unplanned pregnancy, incomplete abortion; obstetric emergencies presenting at health facilities; CPR. It may be more appropriate to provide the complete package of postabortion care services at selected health centers that can serve more a number of villages in close proximity. Other facilities could evaluate, stabilize and refer patients to those sites doing complete postabortion care. All facilities should be able to provide postabortion family planning.
2. Clinical training sites could be established in each OD at the following sites: Siam Reap OD – Module 1; the Referral Hospital in Kranlah OD; and Pouk at Angkor Chum OD.
3. Consolidation of postabortion care activities in sites that are doing less than 2 cases per month should be considered. Also increased access to PAC could be accomplished by increasing health facility hours from 4 hours a day to 8 hours/day at selected facilities. .
4. Increased community mobilization activities may increase the demand for PAC services.

Appendix B - Evaluation Tool for Determining Compliance with the Helms Amendment and Mexico City Policy

Agency: RHAC Assessment completed by: Carolyn Curtis Date: TDY 4/23/05 to 5/6/05

Organizations	Yes	No	Uncertain
1. Does the organization operate a family planning counseling service that includes as part of the regular program, providing advice and information regarding the benefits and availability of abortion as a method of family planning?		X	
2a. Does the organization provide information that abortion is an available option in the event other methods of family planning are not used?	.	X	
2b. Does the organization provide information that abortion is an available option in the event other methods of family planning are not successful?		X	
3. Does the organization encourage women to consider abortion?		X	
4a. Does the organization lobby a foreign government to legalize or make available abortion as a method of family planning?			No inquiry made
4b. Does the organization lobby a foreign government to continue the legality of abortion as a method of family planning?			No inquiry made
5. Does the organization conduct a public information campaign in USAID-recipient countries regarding the benefits and/or availability of abortion as a method of family planning?		X	
6. Does the organization provide any assistance (financial or technical) to the government in support of its abortion activities?			No inquiry made
7. If the organization has provided funding to the government, does it have evidence that the funds have been place in a segregated account to ensure that such funds are not used to support the abortion activity of the government?			N/A
8. Does the organization have a policy or disclaimer for employees to ensure that the employee does not improperly represent that the individual is acting on behalf of the organization in regard to requests or referrals for abortion?		X	
If you check *yes or uncertain* on items 1-6, further evaluation is needed to determine possible violations of Helms Amendment and Mexico City Policy. **If you check *no or uncertain* on items 7 or 8, further evaluation is needed to determine possible violations of Helms Amendment and Mexico City Policy.**			

Comments: RHAC stated that it its staff did not perform abortions or any abortion related activity. However, further inquiry needs to be made to validate that they do not lobby the government to legalize abortion; do not lobby the government to continue its abortion legislation; or provide any technical assistance to the government to support its abortion activities. RHAC noted that they had educated their staff on the Mexico City Policy; however, no inquiry was made for documentation of staff meetings indicating Helms Amendment and Mexico City Policy as topics for education/discussion. Also, there was no inquiry made re: the presence of a policy or disclaimer statement to ensure that employees do not improperly represent the agency in regard to activities they conduct as individual providers. Recommend that RHAC establish organizational policies and disclaimer statement for handling Mexico City/Helms Amendment. Also recommend inclusion of written information on Mexico City and Helms Amendment in training curriculum.

Agency: RACHA Assessment by: Carolyn Curtis Date: TDY 4/23/05 -5/6/05

Organizations	Yes	No	Uncertain
1. Does the organization operate a family planning counseling service that includes as part of the regular program, providing advice and information regarding the benefits and availability of abortion as a method of family planning?		X	
2a. Does the organization provide information that abortion is an available option in the event other methods of family planning are not used?	.	X	
2b. Does the organization provide information that abortion is an available option in the event other methods of family planning are not successful?		X	
3. Does the organization encourage women to consider abortion?		X	
4a. Does the organization lobby a foreign government to legalize or make available abortion as a method of family planning?			No inquiry made
4b. Does the organization lobby a foreign government to continue the legality of abortion as a method of family planning?			No inquiry made
5. Does the organization conduct a public information campaign in USAID-recipient countries regarding the benefits and/or availability of abortion as a method of family planning?		X	
6. Does the organization provide any assistance (financial or technical) to the government in support of its abortion activities?			Provide MVA training for postabortion care
7. If the organization has provided funding to the government, does it have evidence that the funds have been place in a segregated account to ensure that such funds are not used to support the abortion activity of the government?			Not applicable
8. Does the organization have a policy or disclaimer for employees to ensure that the employee does not improperly represent that the individual is acting on behalf of the organization in regard to requests or referrals for abortion?		X	
If you check *yes or uncertain* on items 1-6, further evaluation is needed to determine possible violations of Helms Amendment and Mexico City Policy. **If you check *no or uncertain* on items 7 or 8, further evaluation is needed to determine possible violations of Helms Amendment and Mexico City Policy.**			

Comments: RACHA provides technical assistance to the MOH in Life Saving Skills training and postabortion care training. They provide MVA equipment to the government for postabortion care activities. They are concerned about the use of MVA by MOH staff for abortion services. They also provide education to the community, TBAs and Village Health Support Groups (VHSGs) on complications of unsafe abortion. This education is held as a means of prevention of unsafe abortion. They have informed the trainees (midwives)
on Mexico City policy, although no documentation of this information was verified. They were instructed by me that they once employees are off duty; they are not under the jurisdiction of RACHA. Recommend that RACHA establish policies for staff regarding Helms Amendment and Mexico City compliance as well as have disclaimer statement for use if employees act on their own behalf in regard to abortion activities. Recommend that Helms Amendment and Mexico City policy written information be included in postabortion care curriculum and regular meetings for update/refresher training on Helms Amendment/Mexico City policy be held. This information needs to also be provided to TBAs and VHSGs.

Agency: Care/Cambodia - Uncertain if the operating legal entity is US based NGO or foreign NGO. Assessment done by Carolyn Curtis during TDY 4/23/05 to 5/6/05.

Organizations	Yes	No	Uncertain
1. Does the organization operate a family planning counseling service that includes as part of the regular program, providing advice and information regarding the benefits and availability of abortion as a method of family planning?			Possible in work with MOH
2a. Does the organization provide information that abortion is an available option in the event other methods of family planning are not used?	.		Possible in work with MOH
2b. Does the organization provide information that abortion is an available option in the event other methods of family planning are not successful?			Possible in work with MOH
3. Does the organization encourage women to consider abortion?			Possible in work with MOH
4a. Does the organization lobby a foreign government to legalize or make available abortion as a method of family planning?		X	
4b. Does the organization lobby a foreign government to continue the legality of abortion as a method of family planning?		X	
5. Does the organization conduct a public information campaign in USAID-recipient countries regarding the benefits and/or availability of abortion as a method of family planning?			Possible in work with MOH
6. Does the organization provide any assistance (financial or technical) to the government in support of its abortion activities?			Very possible in its policy work with MOH
7. If the organization has provided funding to the government, does it have evidence that the funds have been place in a segregated account to ensure that such funds are not used to support the abortion activity of the government?			May not be applicable
8. Does the organization have a policy or disclaimer for employees to ensure that the employee does not improperly represent that the individual is acting on behalf of the organization in regard to requests or referrals for abortion?		X	May not be applicable if CARE is US NGO
If you check *yes or uncertain* on items 1-6, further evaluation is needed to determine possible violations of Helms Amendment and Mexico City Policy. **If you check *no or uncertain* on items 7 or 8, further evaluation is needed to determine possible violations of Helms Amendment and Mexico City Policy.**			

Comments: CARE is responsible for managerial of public health facilities. This includes staffing; personnel, everything. They are also working with health systems strengthening. CARE with USAID funding is working on government policies re: incomplete abortion and are concerned re: how to address illegal, incomplete abortion while remaining compliant with Mexico City Policy as they are managing health facilities on behalf of the government. They are concerned about protocols around abortion and how government employed personnel are able to deliver on abortion services under their management.

Appendix C - Evaluation Tool for Determining Compliance with the Helms Amendment and Mexico City Policy

Agency: _____Assessment completed by: _____Date: _____

Organizations	Yes	No	Uncertain
1. Does the organization operate a family planning counseling service that includes as part of the regular program, providing advice and information regarding the benefits and availability of abortion as a method of family planning?			
2a. Does the organization provide information that abortion is an available option in the event other methods of family planning are not used?	.		
2b. Does the organization provide information that abortion is an available option in the event other methods of family planning are not successful?			
3. Does the organization encourage women to consider abortion?			
4a. Does the organization lobby a foreign government to legalize or make available abortion as a method of family planning?			
4b. Does the organization lobby a foreign government to continue the legality of abortion as a method of family planning?			
5. Does the organization conduct a public information campaign in USAID-recipient countries regarding the benefits and/or availability of abortion as a method of family planning?			
6. Does the organization provide any assistance (financial or technical) to the government in support of its abortion activities?			
7. If the organization has provided funding to the government, does it have evidence that the funds have been place in a segregated account to ensure that such funds are not used to support the abortion activity of the government?			
8. Does the organization have a policy or disclaimer for employees to ensure that the employee does not improperly represent that the individual is acting on behalf of the organization in regard to requests or referrals for abortion?			
If you check *yes or uncertain* on items 1-6, further evaluation is needed to determine possible violations of Helms Amendment and Mexico City Policy. **If you check *no or uncertain* on items 7 or 8, further evaluation is needed to determine possible violations of Helms Amendment and Mexico City Policy.**			

This tool will allow USAID/Cambodia to do a quick assessment of organizations for their compliance with Mexico City Policy/Helms Amendment. This tool is for internal USAID/Cambodia use only.

Appendix D - How to use the Register for Postabortion Care

The Register for postabortion care is a tool which will enable the organization/health center to gather data for reporting. It is meant to be user friendly by using check marks as much as possible with little need to write in data. Please note the following instructions for using the Register for Postabortion Care.

Top of the page, each page notes the component of PAC services that is being addressed with the data captured. Write in the name of the organization/health facility and check off the month that the data collection is for and write in the year.

Item # 1 – Number - Write in the number of the patient for that month This information will allow the facility to answer indicator # 1 – Number of women triaged and referred for PAC services in the past year; and indicator # 2 – Number of women provided emergency PAC treatment during the past year.

Item # 2 – Date – write in the date

Item # 3 – First name and surname – Write in the patient's name

Item # 4 – Exact Address – Write in the information, this will assist in home f/u as needed. Your facility may choose to not collect this information

Item # 5 – Age – Write in the patient's age. This information will allow the facility to answer Intermediate Result # 1.4 – Number and percentage of clients served by PAC programs who are members of vulnerable or underserved populations (adolescents, etc)

Item # 6 – Gravida – Write in the number of pregnancies

Item # 7 – Parity – Write in the number of deliveries

Item # 8 – Patient transferred? Check yes or no. This information will allow the facility to answer Indicator #1. In sites where emergency treatment is not available, the number of women triaged and referred for PAC emergency treatment in the past year.

Item #9- Name of facility transferred to/from: Write in the name of the facility that you transferred a patient to or the name of the facility from which you received a patient transfer.

Item #10. Method of Uterine evacuation – Check all that apply

Item # 11 – Pain Medication Used – Check all that apply

Item # 12 – Complications – Check all that apply

Item # 13 – Family Planning Counseling completed? Check yes or No. This information will allow the facility to answer Indictor # 3 – Of the number of women receiving PAC services during the past year, the number and percentage of women who received family planning counseling prior to leaving the facility.

Item # 14 – Family Planning Method received or Referral Made for Family Planning Method Prior to leaving the facility. If the method was provided AT THE SAME TIME AND LOCATION AS PAC EMERGENCY TREATMENT, make an "X" for the method received. If the patient WAS REFERRED TO ANOTHER PLACE IN THE FACILITY (i.e. FP clinic, FP counseling room) OR ELSEWHERE for services, make a "R" for the method desired. This information will allow the facility to answer Indicators 4 and 5; Indicator 4. Of those women receiving PAC service during the past year, the number and percentage of women who received a family planning method prior to leaving the facility. Indicator 5 - Of those women receiving PAC service during the past year, the number and percentage of women referred for a family planning method prior to leaving the facility.

Item # 15 – STI evaluation Completed? Check Yes or No. This information will allow the facility to answer Intermediate Result (IR) 1.3 – The number and percentage of PAC clients who receive STI or HIV/AIDS services during a given visit. (Country programs will decide if they will integrate STI evaluation into PAC services)

Item # 16. HIV Counseling Completed? Check Yes or No. This information will allow the facility to answer Intermediate Result (IR) 1.3 – The number and percentage of PAC clients who receive STI or HIV/AIDS services during a given visit. (HIV counseling and testing services is suggested only for those countries in which there is a high prevalence of HIV.)

Item # 17 – HIV Testing Completed? Check Yes or No. This information will allow the facility to answer Intermediate Result (IR) 1.3 – The number and percentage of PAC clients who receive STI or HIV/AIDS services during a given visit. (HIV counseling and testing services is suggested only for those countries in which there is a high prevalence of HIV.)

Item # 18 – Comments – Write in any pertinent comments regarding the patient that are not captured in the other categories.

Item #19 – Signature – Write in the name of the person completing the postabortion care procedure into the log book.

Appendix E – Register for Postabortion Care

APPENDIX F: POLICY REVIEW

CAMBODIA: PAC Scale Up

Review of Safe Motherhood National Policy and Strategies (December 1997) for incorporation of Postabortion Care

PART 1: Policy

April 28, 2005
J. Ahlborg, B. Farrell

Findings

Page 2 – Incorporate abortion statistics in the *Introduction*.

Page 3 - "Safe Motherhood Principles" contain four pillars, family planning, antenatal care, clean labor and delivery; and essential obstetric care that must be integrated into the district health system and supported by gender equity. Inclusion of postabortion care (PAC) within the four pillars may be positioned with (a) antenatal care and (b) essential obstetric care. While inclusion of the management of signs and symptoms of incomplete abortion and abortion complications may occur outside of access to ANC, ANC is a point at which women experiencing a spontaneous abortion may be able to access appropriate and timely treatment; women should also access appropriate and timely treatment wherever essential obstetric care is available.

Page 4 – "Maternity care services will be expanded and improved at all levels to:

- Bullet 3 will imply PAC skills when documents incorporated PAC into the SM Principles and as articulated within the Essential and Comprehensive Obstetric Care package.
- Bullet 6, modify as, "Increases the awareness of families, men, and women throughout pregnancy recognizing danger signs and the importance of community participation in organizing emergency transport, blood donors, and to saving…"
- Bullet 7, Strengthen referral level services …to provide emergency obstetric care *including postabortion care…"*
- Bullet 8, "Assure availability of obstetric services *including postabortion care…*" (PAC captured on page 5, EOC).
- Bullet 11, "Review curricula and organize in-services training for…including postabortion care and birth spacing. <u>Note:</u> *Clarify birth spacing to include counseling + provision of methods and/or counseling and referral.*
- Bullet 12, (PAC captured in SM)

Page 5, **Maternity Services** insert second paragraph for *Counseling*. "*Counseling* is an essential and integral part of each component of care throughout pregnancy including care provided under Basic and Comprehensive obstetric care."
"COMPONENTS"
<u>Care throughout Pregnancy</u>:

- **Antenatal Care** – at least two antenatal care visits during pregnancy including risk screening / early detection of danger signs and appropriate treatment and referral; tetanus toxoid immunization (2), anemia prophylaxis (90 iron / folate tablets for each pregnant woman); diagnosis and treatment of anemia; syndromic treatment of STD; *VCCT; PMTCT;* health education on danger signs, nutrition, and harmful traditional practices, place of delivery with transport problems activity, breastfeeding and birth spacing counseling.

Organization of transport for obstetric emergencies for community / health center.

- **Labor and Delivery care** – labor management with a partograph, safe / clean labor including detection of fetal and maternal complications with appropriate referral;
- **Postnatal Care** – control of bleeding in the third stage; resuscitation, thermal control; early breastfeeding of the newborn, and obstetric first aid.
- **Postabortion Care** – manage signs and symptoms of incomplete abortion and abortion complications, provide postabortion family planning; assess for STI and HIV risk; refer to relevant health services; and / or stabilize and transfer.

Page 5, **Essential obstetric care (EOC): Basic HC level**, add
-Analgesia, local anesthesia
*PAC included for uterine evacuation of retrained products of conception.

Page 6, **Comprehensive EOC at first referral level (hospital)**,
*PAC included in first bullet for uterine evacuation, management of complication.
-add analgesia

Following **POSTNATAL CARE**, consider return visit for PAC follow-up after 7 days.

Birth Spacing - *Includes reference to PAC.

Equipment, Drugs, and Supplies - *Implies PAC by referencing EOC.

IEC Materials – "availability and distribution of materials relative to antenatal, labor / delivery, postnatal, *postabortion care*, child spacing, newborn care and danger signs."

Page 7, **5.1 Family/Community Level**,

- Bullet 1, insert PAC – empower families, TBAs and …knowledge for care of pregnant, *postabortion*, and postpartum women…"

- Bullet 2, Insert PAC – "get families to seek appropriate and timely help from trained health care providers for antenatal, delivery, *postabortion*, and postnatal care, STD / AIDS, and birth spacing.

5.2 Health Centre level,

- Bullet 1, Insert PAC – "Quality antenatal, delivery, *postabortion*, and postnatal care services…"

- Bullet 3, "Recording of services provided to pregnant women / newborns, including complications *of early and late pregnancy or termination of pregnancy*."

- Page 8, bullet 5, *include PAC implication through basic EOC.

5.4 Referral System
Define "functional referral system" to include (a) communication, (b) stabilization, (c) transport, and (d) follow-up.

-Add, “a functional referral system is to be established as an essential component of Safe Motherhood with specific job descriptions and guidelines for providing postabortion care at each level including referral guidelines.”

6. Human Resource Development – Training - *includes reference to PAC.

- Pages 9, bullets 1-5 imply reference to PAC.

8. Information, Education, and Communications (IEC)

- Bullet 1, “create awareness, improve knowledge and change attitude/behavior of target groups for Safe Motherhood, birth spacing, *pregnancy complications including PAC*, nutrition…”

9. Health Information System – Need to include reference to PAC indicators; Annex 1 needs to include PAC indicators.

10. Monitoring and Evaluation

Page 10, bullet 1, *Note*: “periodic monitoring” should include PAC and its contribution to Safe Motherhood strategies.

11. Financing

*Page 11, bullet 3, implies PAC.

12. Coordination at Central and Provincial Level

Bullet 1, “integration of Safe Motherhood components within existing MCH and related programs (EPI, birth spacing, *PAC*, STD/HIV/AIDS, and nutrition)…”

CAMBODIA: PAC Scale Up

Review of Safe Motherhood National Policy and Strategies (December 1997) for incorporation of Postabortion Care

PART 2: Strategies

J. Ahlborg, B. Farrell

Page 7, **Family and Community Level**, 1.1, add at the end of the statement, "that every woman with signs and symptoms of incomplete abortion or abortion complications seeks treatment in a timely manner.

Page 9, *1.13, includes PAC.

- 1.15, bullet 2, include "risk assessment for HIV, referral for VCCT and PMTCT".
- 1.16, include *analgesia, local anesthesia* that would be used in EOC.
- 1.17, *includes PAC.

Pages 11, 1.20, add "*Essential* obstetric services…" which will imply PAC.

- 1.11 Includes PAC.
- After 1.24, insert, "Incorporate guidelines for all elements of PAC."
- Page 12, 1.29 *implies PAC.
- 1.30 *implies PAC.
- 2.1 references PAC.

Page 13, Table 1, update to include job descriptions of midwives to address:

- ✓ STI management
- ✓ HIV assessment, referral for VCCT, PMTCT. *Note:* Import if articulated in other guidelines.

Page 15, Practical Training on Safe Motherhood components in medical faculty curricula:

- Third year – add, "including postabortion care (assessment, stabilization, uterine evacuation, counseling, family planning).
- Fourth / Fifth year – add, "postabortion care".

Page 16, In-service training: *2.13, includes reference to PAC.
Page 17, *2.17, includes reference to PAC.

- 3.1, include reference to PAC indicators.
- 3.2, include "number of pregnant women screened for HIV"
- Page 18, 4.3, implies PAC.

Appendix 1, add PAC indicators to the table.

APPENDIX G: TECHNICAL MATERIAL REVIEW

USAID/Cambodia PAC Scale-Up
Review of Comprehensive Postabortion Care document

May 4, 2005

The above titled document is composed of an introductory chapter and 9 chapters. The **introductory** chapter sets the Cambodia background for maternal morbidity and mortality related to complications of unsafe abortion. It also articulates three elements of PAC and references community awareness as cross-cutting the three elements. Elements are not consistent with the USAID October 2004 model reflecting an absence of reference to STI and HIV risk assessment, STI management and/or referral for STI management and HIV counseling and testing. This document does not address community awareness and mobilization to increase access to PAC services. The document did not have a cover page or additional content identifying the author or audience; how this document was to be used, nor date of publication.

On request, the RACHA staff provided the agenda, lesson plans, and training/job aids that form the training package for PAC services with the training/reference manual described below. There is a separate curriculum for the community mobilization component of the PAC program (Catalyst funded). This was developed later, but is implemented in the villages surrounding rural health centers with trained, equipped providers.

Content covered includes the following:

Chapter 1 Management of s/s of incomplete abortion - including management algorithms

Chapter 2 MVA equipment – complete lists equipment, components, and assembly.

Chapter 3 Pain management - includes the range of management drugs including narcotic (2) and tranquilizer (1), as well as non-narcotics (2). Few of the suggested medications are available at the health center level.

Chapter 4 Infection prevention - gives specific guidance for care of MVA syringes and cannulae.

Chapter 5 Communication - provides basic information on dynamics of communication; mention of values and attitudes in PAC; and suggests statements for supporting clients receiving PAC.

Chapter 6 Counseling - briefly covers components and skills of counseling; includes an information box related to factors for FP decision-making; could be strengthened to include cases for skills practices if this document is envisioned to support training.

Chapter 7 Postabortion family planning - includes return of fertility, range of contraceptive options, and guidance for client conditions that would indicate appropriate/inappropriate methods use immediately postabortion. Includes reference to FP methods' role in protecting against STI and HIV. Need to update information in "disadvantages" column for vasectomy and NFP.

Chapter 8 Linkages - includes range of referral needs for women presenting with s/s of incomplete abortion; include management of STI (etiologic) and drug regimens.

Chapter 9 Organization of services – provides a list of equipment, supplies, and furnishings for PAC but does not include drugs or reference the pain management chapter. Does not include information on how to supervise PAC services or use of supervisory tools for monitoring quality. Does not include guidance for managing services (set of space; tailoring of systems to facilitate PAC, commodity logistics, recordkeeping, referral).

APPENDIX H: Suggested revisions of current PAC curriculum for secondary midwives

Current course schedule:

	Day 1	Day 2	Day 3	Day 4
AM	Introduction/ Expectations Overview PAC key elements Mgmt complications: Assessment	MVA equip and procedure Demonstrate and practice Pain management	Communication skills PAC BS	Counseling role plays MVA procedure practice Instrmt proc pract
PM	Complications: Shock, other life threatening complic Case study Intro MVA equip	Infection prevention MVA instr processing practice	Linkages to other RH Post abortion counseling	Additional practice Organization of services Post test Evaluation PAC report form

Proposed additions/modifications

sess	D1	D2	D3	D4	D5
AM	Intro/orient Overview/ab and PAC Range/mgmt complic Key PAC components Comm skills	MVA/UE in PAC services Demo/practice with instrumts Practice on models	Infn preventn MVA instr proc. Practice in assoc with procedure practice	BS for PAC Other RH services (STI/RTI, VCCT, other)	Skills check: Comm/Couns MVA proc Instrument processing Model practice, role plays, clinical practice
PM	Assessment Treatment Stablztn/Ref Practice assessment/ Case studies, role plays	Pain management MVA and communication skills: role plays/model practice Clinical practice	Comuncation skills for PAC, before, during, after Demnstration Role plays Clinical practice	Discharge counseling, follow-up, referral Role plays, model practice Clinical practice	Organization of services Monitoring/ Record keeping Action plans Knowledge p/test Evaluation

Appendix I - Recommendations by Betty Farrell and Jean Ahlborg for ACQUIRE Activities

ACQUIRE Program Planning Design for PAC Scale-up

Overall program approach for PAC scale-up is to strengthen and scale up PAC activities in the public sector through RACHA's work, first in the existing ODs and then expanding PAC activities in new districts, once policy, standards/guidelines and training curricula are modified and standardized. Technical assistance will be provided to RHAC for expansion of PAC in the private sector. Planned activities fall under three categories as follows:

- ✓ Development of a consistent policy/enabling environment
- ✓ Strengthening training and program support (including monitoring, supervision, and quality improvement)
- ✓ Expanding community involvement.

Policy

- Clarify with the PAC Team Leader and Barbara Seligman language to guide the USAID Mission, NGO partners, and MOH in negotiating the restrictions of Mexico City Policy and Helms Amendment.
- Through a series of meetings and workshops, ACQ should work with the MOH, RACHA, RHAC and other stakeholders to define a PAC-specific policy and guidelines within the activities of the MOH's PAC Technical Working Group. The first such meeting is planned for May 18th, with the expectation that this will be part of a developing national RH strategy, a draft of which will hopefully be available in June.
- A draft PAC policy outline was requested by USAID/Cambodia, Charya Sokun Hen to facilitate the work of MOH in promoting PAC. A copy will be made available to Ms. Hen by May 13, 2005. It should serve as a starting point for the terms of reference of the PAC Technical Working Group.

Training for PAC Service Delivery

- Review and modification of the existing PAC curriculum, in cooperation with existing PAC trainers. This will be informed by efforts at the national effort to develop a standardized curriculum for PAC.
- Alternatives to central, large group-based training in PAC which should include assistance in finding skills practice opportunities in other countries for minimally the master trainers for reinforcement of skills and confidence building. Uterine evacuation and counseling skills need more attention during the training, ideally both model and patient practice. Provision of supportive supervision and coaching on-site
- The number (and location, variety and skills) of PAC trainers will be increased through additional training of trainers, among those skilled in counseling and a variety of uterine evacuation techniques. This refresher training (for existing trainers) and initial TOT for new trainers will occur once a PAC curriculum is standardized.
- Performance standards will be utilized as criteria for successful completion of training.
- Training will be designed to incorporate an increasing range of topics, for potentially varied audiences (range of uterine evacuation options, range of FP counseling and SRH services). Existing approved MOH training materials (e.g. in birth spacing counseling and services, diagnosis and management of RTI/STIs, and VCCT, where appropriate) will continue to be integrated into PAC training.
- Reinforce PAC supervision for quality of care; support monitoring the collection of PAC service statistics; strengthen systems such as services management and recordkeeping.
- Refine PAC monitoring and evaluation activities.

Community Awareness and Mobilization

- Assist RACHA's training team to build-in the expanded role of community awareness and mobilization in supporting PAC services utilization.
- Initiate a review process for assessing the degree to which the Bolivia PAC Community pilot might be implemented in Cambodia.
- Increase male involvement in awareness raising activities at the community level to maximize women's use of PAC services including family planning.
- Evaluate challenges and identify ways to facilitate referrals.

ACQUIRE Program Planning Design for Starting New PAC Services
In expansion sites, ACQUIRE with RACHA and RHAC partners should:

- Plan and conduct a needs assessment to determine need for services and appropriate staff/facilities for intervention.
- Use updated training curriculum and draft training plans for new services,
- Implement enhanced community awareness and mobilization activities, and
- Develop PAC monitoring and evaluation activities in relation to required program activities and related indicators.

Through the technical guidance of the PAC Team Leader with the USAID/Cambodia Mission staff, and from the list of PAC field indicators, ACQUIRE program activities would be able to report on the following Illustrative Indicators:

IR 1 – PAC expanded and supported through services delivery
1.2 Number and percentage of service delivery points providing PAC services that meet a defined standard of quality care.
1.3 Number and percentage of PAC clients who receive STI/HIV/AIDS services (or referral) during a given visit
1.4 Number and percentage of clients served by PAC programs who are members of vulnerable or underserved populations, e.g., adolescents

IR 2 – PAC policy and advocacy supported and advanced

2.1 Number of service delivery points where PAC service activities are incorporated into standard protocols (as the PAC program matures)

IR 3 – PAC services expanded and supported through community empowerment via community awareness and mobilization

3.4 Number and percentage of men and women aged 15-49 who can cite one danger sign of an obstetric emergency/bleeding in early pregnancy.

Next steps for ACQUIRE:

1. Work with MOH and local partners to create enabling PAC environment, through development of a PAC policy/strategy, standards and guidelines, and supporting curriculum/training for appropriate providers. ACQUIRE will provide a PAC policy outline to serve as a reference/basis for discussion. ACQUIRE will attend all subsequent meetings of the Technical Working Group as timing allows, in conjunction with local partners. RACHA will provide support for the Technical Working Group meetings.
2. Work with RHAC central management staff and Phnom Penh clinic provider over the next 2 months to develop supervision and training capacity within the project and consider strategies for increasing clinical training exposure within the project clinic sites. This will include:
    a. Discussion of study tour/practical training options for identified staff members.
    b. Coaching of trained clinical staff with PAC clients seen at Phnom Penh clinic, and using model practice.
    c. Review and development of management protocols consistent with existing RHAC RH protocols, and current MOH guidelines.
    d. Review and development of monitoring checklists and service indicators.
    e. Formal back translation of draft PAC information booklet.
3. ACQUIRE to continue work with RACHA staff to improve PAC training capacity and training materials. Over the course of the visit, several meetings were held with RACHA PAC staff and PAC trainers from the Red Cross Health Center to discuss available training materials and how to improve them, including the need to increase the amount of time for the training, and the flexibility of the schedule to accommodate clinical practice and the unpredictable nature of this (including the possible need to take "call" in the evenings to increase exposure to women with complications of abortion). The need to increase the number of available trainers, the feasibility/advantages of a range of training. A revised draft schedule (see appendix D) was developed for review, as well as a draft comprehensive skills checklist for assessment of practical skills in client assessment, communication, uterine evacuation, pain management, infection prevention and counseling skills related to Birth Spacing and risk/assessment of RTI/STI.

a. Feedback will be collected from staff and participants for incorporation into discussions of the technical working group
b. PAC training of secondary midwives will be observed during next visit (in June) with a focus on development of clinical and communication skills and their objective assessment.
c. RACHA's current plans for PAC expansion will proceed as per 04/05 workplan, using existing materials and current pool of midwife trainers.
d. ACQUIRE to provide TA to RACHA on PAC activities for upcoming fiscal year (2005/2006), to be coordinated as part of workplan development process.